NIAGARA DISTRICT HEALTH COUNCIL
CONSEIL RÉGIONAL DE SANTÉ DE NIAGARA
1428 Pelham Street, P. O. Box 1220, Fonthill, Ontario LOS 1EO
(905) 892-5771◆FAX: (905) 892-1593◆e-mail: general@niagaradhc.on.ca

INTEGRATED ADDICTION TREATMENT SERVICE PLAN FOR NIAGARA

Substance Abuse Task Force Report

January 19, 2000

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EXECUTIVE SUMMARY

In January 1999, the Ontario Substance Abuse Bureau of the Ministry of Health and Long-Term Care released "Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario". The Framework set out three strategies to accomplish the new vision for Ontario's addiction treatment system:

- improve how we delivery services;
- improve how we monitor and evaluate services; and
- improve how we structure, plan and organize addiction services.

The Ministry of Health and Long-Term Care instructed DHC's across the province to undertake a collaborative planning process to lead local communities in the development of:

- A shared vision for addiction treatment services in their communities;
- Guiding goals and principles consistent with the directions established in Setting the Course;
- Plans that will support the integration of addiction services through mergers, amalgamations and service agreements; and
- Priorities which will guide next steps and implementation of the integrated service plans.

Methodology

The Niagara District Health Council established the Substance Abuse Task Force in March 1999 to plan the rationalisation of addiction services in Niagara. The Task Force was made up of six members including a member of the District Health Council. There was also ex-officio representation from the Addiction Services Mobilizing Committee, the Centre for Addiction and Mental Health, the Ontario Substance Abuse Bureau and the Niagara District Health Council. From April 1999 to January 2000, the Task Force held sixteen meetings and participated in a two-day workshop with addiction service providers to develop a system logic model.

In completing an assessment of the current addiction treatment system, the Task Force attempted to involve as many community stakeholders as possible in the planning process. The Task Force hosted eleven client focus groups, one focus group for French-speaking stakeholders, and three community consultations. Approximately 100 clients participated in the focus groups providing some excellent comments and suggestions and approximately 80 individuals attended the two initial community consultations. A "draft" report: "Integrated Addiction Treatment Service Plan for Niagara" was prepared in December and stakeholders were invited to provide a written response or to attend a consultation on January 7th, 2000. Nine written responses were received and forty-five individuals attended this final consultation. Task Force members also reviewed previous addiction planning reports, best advice papers, system reports – Drug and Alcohol Registry of Treatment (DART) and the Drug and Alcohol Treatment Information System (DATIS), as well as a variety of other articles and reports.

Planning Context

The Niagara region is fortunate to have a broad continuum of addiction treatment supports and services. There are fifteen addiction agencies, service providers and consumer groups providing addiction treatment and/or support services, utilising a variety of approaches.

The Addiction Services Mobilizing Committee (ASMC) is the planning coordinating mechanism for the system. Currently there are eighteen members representing addiction service agencies and other community social services. Participation is voluntary; it is a network, without binding decision-making authority.

In 1998-99, the Ontario Substance Abuse Bureau provided $4,222,773 to six treatment agencies in Niagara. In Niagara the largest portion of OSAB funding is directed to residential programs and services. In comparing number of clients served in residential programs and community-based programs as a per cent of total Niagara funding allocation from OSAB, the majority of funding (71.2%) is directed to residential services which provides programming to 20% of total individuals served.

The Niagara budget allocation from OSAB has remained virtually unchanged since 1992. Taking into account increased operating expenses including pay equity obligations, increased benefit costs, rising rent and supply expenses, union settlements and inflation, the Niagara addiction system has in fact realised a loss of operating revenue. In addition, agencies have had to manage rising caseloads, and more complex service requirements, placing increasing pressures on the staff of the addiction agencies.

Needs Assessment

Four common themes emerged from the input provided through the consultations relating to accessibility, gaps in service, quality of service and system integration.

Accessibility

Stakeholders identified the need for more community information on addiction services, better transportation services in the region, additional childcare supports, and increased resources for services.

Gaps in service

A variety of service gaps were identified including: a women's level 1 recovery home; services for special population groups such as youth, seniors and individuals with concurrent diagnosis; and medical supports and services.

Quality of service

Community members stated there was a need for more resources in the addiction system, need for more staff training and development and a need for medical and psychiatric assessments to assist in treatment planning.

System integration

Niagara stakeholders, including clients, addiction treatment service providers and other community partners stated there was a need for more coordination, cooperation and system planning in the current addiction system.

Integrated Service Plan for Niagara Region

In developing the integrated service plan for Niagara, the Substance Abuse Task Force attempted to make the best use of the limited resources within the current addiction system. Although OSAB clearly indicated that no new money would be available to the system, service plans were asked to identify additional service requirements. OSAB also stated that transitional funding for one-time expenses associated with re-structuring might be provided.

The Task Force developed twenty-two recommendations in support of the three strategies outlined in "Setting the Course". The Niagara service plan sets out a process to enhance system planning and coordination, and to improve services to individual clients. The main recommendation speaks to the development of a community-based coordinating network with system planning authority to replace the current Addiction Services Mobilizing Committee. This network, the Addiction Treatment Network of Niagara (ATNN), would perform more in-depth needs analysis and determine the priority ranking of the recommendations relating to the delivery of treatment services in Niagara. It is recognized that the plan will take three to five years to implement, but the vision to improve system planning and improve service delivery to clients is established by the plan. It is further recommended that a six-month interim board be established to oversee the development of the ATNN.

Task Force members expressed grave concern that the continued under-funding of the addiction treatment system by OSAB where budgets have been frozen since 1992 will soon compromise addiction treatment services in Niagara, as well as across Ontario. Members believe that additional resources must be immediately invested to address the gaps and stresses in the system. It is suggested that an investment in the addiction system would free up resources in the province by reducing spiraling costs to the health care system, criminal justice system and other community support services.

The following is a summary of recommendations contained in the integrated addiction treatment service for Niagara.

Summary of Recommendations

1. That the Addiction Treatment Network of Niagara (ATNN), be formed in the near future to replace the current Addiction Services Mobilizing Committee, to be accountable to and endorsed by the Ontario Substance Abuse Bureau (OSAB), Ministry of Health and Long-Term Care, with the following scope of authority and areas of responsibility:

- ensure needs assessments are performed as required, to prioritise recommendations of the Niagara Substance Abuse Task Force and to monitor the implementation of those priority recommendations;
- engage in system planning;
- facilitate collaboration and integration in the delivery of substance abuse services by member organisations;
- promote evidence-based programs; and
- foster coordination of addiction services with other community services in Niagara, including health care, mental health and social services.

2. That a six-month interim board be established with two representatives from each OSAB-funded addiction treatment agency, as well as broad-based community membership, to oversee the development of the ATNN, with tasks including, but not limited to: hiring a staff coordinator to provide administrative support to the work of the interim board as well as the future ATNN; developing terms of reference and a workplan for the ATNN; and generally overseeing the development of the ATNN to a fully functioning network.

3. That the interim board access one-time transitional funding from OSAB, with the NDHC serving as the flow-through agency, to establish the ATTN, support a staff coordinator for a period of two years, purchase computer hardware for addiction treatment service providers if required, and set up a Niagara addiction treatment system electronic database/client file compatible with the mental health system.

4. That ATNN take the lead to identify community training and information needs and develop a coordinated, consistent approach to community education, social marketing and fund-raising activities across the addiction treatment system.

5. That ATNN investigate the feasibility of establishing centralised access (perhaps integrated with the mental health system in Niagara), a 1-800 number for the region of Niagara and centralised data collection which would be compatible with other addiction treatment systems.

6. That ATNN establish case management benchmarks for Niagara addiction treatment system.

7. That a system-wide case management service be established which incorporates identification of a primary worker (case manager); use of an electronic client file; and access to information from across the addiction system.

8. That OSAB continue to provide training for addiction treatment service agencies in order to implement the standard assessment protocols and standardised admission and discharge criteria, and to provide this training to other relevant community stakeholders as required.

9. That ATNN complete a thorough study including a cost/benefit analysis to provide direction in proposing internal and/or external service linkages, affiliations and/or mergers of various addiction treatment programs.

10. That ATNN determine if there is a need to expand community withdrawal management services across the region of Niagara.

11. That ATNN negotiate with the new Niagara Health System to dedicate four acute care beds to level 3 withdrawal management treatment services.

12. That protocols of service be developed with the new Niagara Health System, Hotel Dieu Hospital, local physicians, psychiatrists, psychologists and other health care and community mental health service providers to provide medical health care assessments and treatment services, and mental health supports and services, including psychiatric assessments and treatment services, to individuals accessing addiction treatment.

13. That ATNN determine the current demand for level 1 residential support services for women, and if warranted, apply for funding from OSAB to establish such services.

14. That ATNN establish residential housing and support benchmarks for Niagara.

15. That ATNN review the need to increase methadone services in the Niagara region.

16. That community outpatient treatment and outreach services be provided by a French-speaking worker from the outpatient treatment service agencies, as needed, at the Centre de Santé Communautaire in Welland.

17. That supported community withdrawal or medical withdrawal be explored as an option for French-speaking detox clients through the needs assessment to be performed by the ATNN.

18. That OSAB, in consultation with the ATNN, establish a residential treatment service for French-speaking individuals located in the southern part of the province (Central East, Central West, Central South and South West, Ontario).

19. That ATNN determine service needs for special populations in Niagara with particular attention to youth, seniors, women and individuals with concurrent disorders.

20. That OSAB immediately undertake a provincial budgetary review of OSAB funded programs including a full review of staff salary and benefit levels.

21. That the Niagara District Health Council approve the appointment of a NDHC staff member in an ex-officio capacity on ATNN.

22. That the ATNN review individual addiction agency operating plans from a system perspective, provide feedback to the agencies on the review, and forward a system operating plan to the District Health Council, in their role to provide advice to the Ministry of Health and Long-Term Care.

SOMMAIRE

Au mois de janvier 1999, le Bureau ontarien de lutte contre la toxicomanie du ministère de la Santé et des Soins de longue durée a publié un document intitulé *Vers de nouvelles orientations : Cadre de mise en oeuvre des services de traitement de la toxicomanie en Ontario*. Dans ce document, on énonce trois stratégies qui permettront de concrétiser la nouvelle vision du système de traitement de la toxicomanie de l'Ontario :

- améliorer la prestation des services;
- améliorer la surveillance et l'évaluation des services;
- améliorer la structure, la planification et l'organisation des services de toxicomanie.

Le ministère de la Santé et des Soins de longue durée a chargé les CRS partout en Ontario d'entreprendre un processus de planification collectif pour diriger les communautés locales dans l'élaboration de ce qui suit :

- une vision partagée des services de traitement de la toxicomanie dans leurs communautés;
- des buts et principes directeurs qui sont conformes aux directives établies dans le document *Vers de nouvelles orientations*;
- des plans qui appuieront l'intégration des services de toxicomanie au moyen de fusionnements, d'amalgamations et d'ententes de service;
- des priorités qui guideront les prochaines étapes ainsi que la mise en oeuvre des plans de services intégrés.

Méthodologie

Le Conseil régional de santé de Niagara a établi le Groupe de travail sur les services de toxicomanie au mois de mars 1999 en vue de planifier la rationalisation des services de toxicomanie de Niagara. Le Groupe de travail était composé de six membres, y compris un membre du Conseil régional de santé de Niagara. Il comptait aussi des membres d'office représentant le Comité de mobilisation des services de toxicomanie, le Centre de toxicomanie et de santé mentale, le Bureau ontarien de lutte contre la toxicomanie et le Conseil régional de santé de Niagara. D'avril 1999 à janvier 2000, les membres du Groupe de travail ont tenu 16 réunions et ont participé, avec des prestateurs de services de toxicomanie, à un atelier d'une durée de deux jours en vue d'élaborer un modèle logique de système.

Dans le cadre d'une évaluation du système actuel de services de traitement de la toxicomanie, le Groupe de travail a tenté de faire participer le plus grand nombre possible d'intervenants communautaires au processus de planification. Il a organisé onze groupes de discussion à l'intention des clients, un groupe de discussion pour les intervenants francophones et trois consultations communautaires. Environ 100 clients ont participé aux groupes de discussion; les commentaires et les suggestions recueillis étaient excellents. Pour ce qui est des deux premières consultations communautaires, près de 80 personnes y ont assisté. L'ébauche d'un document intitulé *Plan intégré*

des services de traitement de la toxicomanie pour Niagara a été préparée en décembre. On a invité les intervenants à fournir une réponse écrite au document ou à assister à une consultation tenue le 7 janvier 2000. On a reçu neuf réponses écrites et quarante-cinq personnes ont assisté à cette dernière consultation. Les membres du Groupe de travail ont aussi examiné des rapports précédents sur la planification des services de toxicomanie, des documents sur les meilleurs conseils, des rapports sur les systèmes (Drogue et alcool – Répertoire des traitements [DART] et Drogue et alcool – Système d'information sur le traitement [DATIS]) ainsi que d'autres articles et rapports variés.

Contexte de la planification

La région de Niagara a la chance de compter toute une gamme de services et de mécanismes de soutien en matière de traitement de la toxicomanie. Quinze organismes de services de toxicomanie, prestateurs de services et groupes d'usagers y assurent la prestation de services de traitement ou de soutien pour les toxicomanes au moyen d'approches diverses.

Le Comité de mobilisation des services de toxicomanie fait fonction de mécanisme de coordination et de planification pour le système. Il compte présentement 18 membres représentant les organismes de services de toxicomanie et d'autres services sociaux communautaires. La participation est facultative; il s'agit d'un réseau sans pouvoir de décision exécutoire.

En 1998-1999, le Bureau ontarien de lutte contre la toxicomanie a versé 4 222 773 $ à six organismes de traitement de la toxicomanie à Niagara. Dans cette région, la plus grande portion des fonds accordés par le Bureau est destinée aux programmes et aux services en établissement. Si l'on compare en pourcentage le nombre de clients desservis par les programmes en établissement et les programmes communautaires à l'ensemble des fonds alloués par le Bureau à la région de Niagara, on constate que la majorité des fonds (71,2 p.100) sont destinés aux services en établissement qui offrent des programmes à 20 p. 100 de l'ensemble des personnes desservies.

Les sommes que le Bureau ontarien de lutte contre la toxicomanie alloue à Niagara sont restées sensiblement les mêmes depuis 1992. Si l'on tient compte de l'augmentation des frais d'exploitation, y compris les obligations en matière d'équité salariale, la hausse du coût des prestations, l'augmentation du loyer et des dépenses en matière de fournitures, les ententes syndicales et l'inflation, on remarque que le système de services de toxicomanie de Niagara a en effet subi une perte de revenus d'exploitation. De plus, les organismes ont dû composer avec une augmentation du volume de cas et des exigences plus complexes en matière de services, ce qui a intensifié les pressions exercées sur le personnel des organismes de services de toxicomanie.

Évaluation des besoins

Quatre thèmes communs sont ressortis des commentaires fournis dans le cadre des consultations : l'accessibilité, les lacunes en matière de services, la qualité des services et l'intégration du système.

Accessibilité

Les intervenants ont relevé les besoins suivants : des renseignements communautaires additionnels sur les services de toxicomanie, des services de transport améliorés dans la région, des services de garde d'enfants supplémentaires et des ressources accrues pour les services.

Lacunes en matière de services

Une variété de lacunes ont été décelées, notamment : un centre de réadaptation pour toxicomanes de niveau 1 à l'intention des femmes, des services pour les groupes spéciaux tels que les jeunes, les aînés et les personnes ayant des troubles jumelés, ainsi que des services et des mécanismes de soutien médicaux.

Qualité des services

Les membres de la communauté ont signalé les besoins suivants : des ressources supplémentaires dans le système de services de toxicomanie, une formation et un perfectionnement plus poussés du personnel ainsi que des évaluations médicales et psychiatriques pour faciliter la planification des traitements.

Intégration du système

Les intervenants de Niagara, y compris les clients, les prestateurs de services de traitement de la toxicomanie et d'autres partenaires communautaires, ont soulevé le besoin d'améliorer la coordination, la collaboration et la planification systémique au sein du système actuel de services de toxicomanie.

Plan intégré de services pour la région de Niagara

En élaborant le plan intégré de services pour la région de Niagara, le Groupe de travail sur les services de toxicomanie a tenté d'utiliser le plus judicieusement possible les ressources limitées du système actuel de services de toxicomanie. Même si le Bureau ontarien de lutte contre la toxicomanie a clairement indiqué qu'aucune somme nouvelle ne serait injectée dans le système, on a demandé que les besoins en matière de services supplémentaires soient énoncés dans les plans de services. Le Bureau a aussi affirmé que des fonds de transition pour les dépenses ponctuelles associées à la restructuration seront peut-être consentis.

Le Groupe de travail a formulé 22 recommandations à l'appui des trois stratégies énoncées dans le document *Vers de nouvelles orientations*. Le plan de services de Niagara décrit un processus visant à améliorer la planification et la coordination du système ainsi que les services offerts aux clients individuels. La principale recommandation porte sur la formation d'un réseau communautaire de coordination qui remplacerait le Comité de mobilisation des services de toxicomanie et qui aurait autorité pour planifier le système. Ce réseau, soit le Réseau des services de traitement de la toxicomanie de Niagara (RSTTN), effectuerait une analyse plus poussée des besoins et classerait par ordre de priorité les recommandations concernant la prestation des services de traitement à Niagara. La mise en oeuvre du plan se fera sur une période de trois à cinq ans, mais le plan énonce clairement la vision de l'amélioration de la planification du système et de la prestation des services aux clients.

Il est aussi recommandé qu'un conseil provisoire soit formé pour une période de six mois afin de surveiller le développement du Réseau.

Les membres du Groupe de travail se sont montrés très inquiets du fait que le sous-financement continu du système de services de traitement de la toxicomanie par le Bureau ontarien de lutte contre la toxicomanie, où les budgets ont été gelés depuis 1992, compromettra bientôt les services de traitement de la toxicomanie offerts à Niagara, de même que partout en Ontario. Les membres croient qu'il faut investir des ressources supplémentaires immédiatement afin de combler les lacunes et de diminuer les tensions dans le système. Il est suggéré qu'un investissement dans le système de toxicomanie libérerait des ressources dans la province en réduisant les coûts croissants du système de soins de santé, du système de justice pénale et d'autres services de soutien communautaires.

Voici un sommaire des recommandations énoncées dans le plan intégré de services de traitement de la toxicomanie pour Niagara.

Sommaire des recommandations

1. Que le Réseau des services de traitement de la toxicomanie de Niagara (RSTTN) soit formé prochainement pour remplacer le Comité de mobilisation des services de toxicomanie, qu'il soit responsable envers le Bureau ontarien de lutte contre la toxicomanie (ministère de la Santé et des Soins de longue durée) et appuyé par celui-ci, et qu'on lui confie l'autorité et les responsabilités suivantes :
    - ♦ veiller à ce que des évaluations des besoins soient effectuées au besoin, prioriser les recommandations du Groupe de travail sur les services de toxicomanie de Niagara et surveiller la mise en oeuvre de ces recommandations prioritaires;
    - ♦ participer à la planification du système;
    - ♦ faciliter, chez les organismes participants, la collaboration à la prestation des services de toxicomanie ainsi que l'intégration de cette prestation;
    - ♦ promouvoir des programmes fondés sur les résultats;
    - ♦ favoriser la coordination des services de toxicomanie avec d'autres services communautaires à Niagara, y compris les services de santé, les services de santé mentale et les services sociaux.

2. Que l'on établisse, pour une période de six mois, un conseil provisoire composé de deux représentants de chacun des organismes de traitement de la toxicomanie financés par le Bureau ontarien de lutte contre la toxicomanie ainsi que d'une vaste gamme de membres de la communauté. Ce conseil surveillerait le développement du RSTTN et assumerait les tâches suivantes, sans pour autant s'y limiter : embaucher un coordonnateur ou une coordonnatrice du personnel pour assurer des services de soutien administratif au conseil provisoire ainsi qu'au futur RSTTN; élaborer un mandat et un plan de travail pour le RSTTN; surveiller le développement du RSTTN jusqu'à ce que celui-ci soit pleinement fonctionnel.

3. Que le conseil provisoire obtienne des fonds de transition ponctuels auprès du Bureau ontarien de lutte contre la toxicomanie (le CRSN servirait d'intermédiaire) pour lui permettre d'établir le RSTTN, d'appuyer un coordonnateur ou une coordonnatrice du personnel pendant deux ans, d'acheter au besoin du matériel informatique pour les prestateurs de services de traitement de la toxicomanie et d'instaurer une base de données/un dossier de clients électronique pour le système de services de traitement de la toxicomanie de Niagara qui soit compatible avec le système de services de santé mentale.

4. Que le RSTTN assume le rôle principal dans la détermination des besoins communautaires en matière de formation et d'information et qu'il élabore une approche coordonnée et cohérente de l'éducation communautaire, du marketing social et des activités de collecte de fonds au sein du système des services de traitement de la toxicomanie.

5. Que le RSTTN examine la faisabilité d'assurer un accès centralisé (l'accès pourrait être intégré au système de services de santé mentale de Niagara), un numéro 1-800 pour la région de Niagara et un système de collecte de données centralisé qui serait compatible avec les autres systèmes de traitement de la toxicomanie.

6. Que le RSTTN établisse des points de repère en matière de gestion de cas pour le système de traitement de la toxicomanie de Niagara.

7. Que l'on établisse, à l'échelle du système, un service de gestion de cas qui comprend la détermination d'un travailleur primaire (gestionnaire de cas), l'utilisation d'un dossier de clients électronique et l'accès aux renseignements dans tout le système de services de toxicomanie.

8. Que le Bureau ontarien de lutte contre la toxicomanie continue d'assurer une formation aux organismes de services de traitement de la toxicomanie afin de mettre en application les protocoles d'évaluation standard ainsi que les critères d'admission et de mise en congé normalisés, et d'offrir cette formation à d'autres intervenants communautaires, au besoin.

9. Que le RSTTN effectue une étude exhaustive, y compris une analyse coûts/avantages, pour le guider dans l'élaboration d'une proposition concernant la création de liens internes ou externes entre les services, d'affiliations ou de fusions de divers programmes de traitement de la toxicomanie.

10. Que le RSTTN détermine s'il est nécessaire d'élargir les services communautaires de gestion du sevrage dans la région de Niagara.

11. Que le RSTTN négocie avec le nouveau Système de santé de Niagara en vue d'affecter quatre lits de soins actifs aux services de gestion du sevrage de niveau 3.

12. Que l'on élabore des protocoles de services avec le nouveau Système de santé de Niagara, l'Hôpital Hôtel-Dieu, les médecins locaux, les psychiatres, les psychologues ainsi que d'autres prestateurs de soins de santé et de services communautaires de santé mentale, afin d'offrir des

évaluations et des services de traitement médicaux ainsi que des soutiens et des services en matière de santé mentale, y compris des évaluations et des services de traitement psychiatriques, aux usagers des services de traitement de la toxicomanie.

13. Que le RSTTN détermine le besoin actuel de services de soutien en établissement pour femmes de niveau 1 et, s'il y a lieu, qu'il demande des fonds auprès du Bureau ontarien de lutte contre la toxicomanie afin d'établir de tels services.

14. Que le RSTTN établisse des points de repère en matière de logement et de soutien en milieu résidentiel pour Niagara.

15. Que le RSTTN examine le besoin d'accroître les services de traitement à la méthadone dans la région de Niagara.

16. Que le Centre de santé communautaire de Welland offre au besoin des services communautaires de traitement en consultation externe et des services d'approche par l'intermédiaire d'un travailleur francophone provenant des organismes de services de traitement en consultation externe.

17. Que l'on examine la possibilité d'offrir des services de sevrage communautaire avec soutien ou des services de sevrage médical aux toxicomanes francophones dans le cadre de l'évaluation des besoins effectuée par le RSTTN.

18. Que le Bureau ontarien de lutte contre la toxicomanie, en consultation avec le RSTTN, mette sur pied un service de traitement en établissement pour les francophones dans le sud de la province (le Centre-Est, le Centre-Ouest, le Centre-Sud et le Sud-Ouest de l'Ontario).

19. Que le RSTTN relève les besoins des populations spéciales de Niagara en matière de services en mettant l'accent sur les jeunes, les aînés, les femmes et les personnes ayant des troubles jumelés.

20. Que le Bureau ontarien de lutte contre la toxicomanie entreprenne immédiatement une étude budgétaire provinciale des programmes financés par le Bureau, y compris une étude complète des salaires et des avantages sociaux du personnel.

21. Que le Conseil régional de santé de Niagara approuve la nomination d'un membre du personnel du CRSN à titre de membre d'office du RSTTN.

22. Que le RSTTN examine les plans de fonctionnement de chaque organisme de services de toxicomanie dans une perspective systémique, fournisse aux organismes des commentaires au sujet de l'étude et achemine au Conseil régional de santé un plan de fonctionnement de système pour que celui-ci puisse fournir des conseils au ministère de la Santé et des Soins de longue durée.

1 INTRODUCTION

1.1 Background to Addiction Rationalization Process

In January 1999, the Ontario Substance Abuse Bureau of the Ministry of Health and Long-Term Care released **"Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario"**. The document provides a brief history and description of Ontario's current addiction treatment services, and sets out a vision for a more integrated, client-focused service delivery system. In 1997/98 the Ontario Substance Abuse Bureau (OSAB) provided approximately $110 million for addiction programs, including assessment, referral, detoxification services, outpatient services, residential treatment services and recovery homes. As with other health and social service systems, addiction treatment services are being asked to be more accountable for their funding and to become more efficient. Increasingly, there are pressures on agencies to provide more services to more diverse clients, to keep up with new research and treatment approaches, and to provide services in a coordinated seamless manner.

Building on the OSAB commissioned restructuring studies completed in 1997, the framework sets out three strategies to accomplish the new vision for Ontario's addiction treatment system:

1) **Improve how we delivery services**

- Using evidence-based practice
- Making it faster and easier for people to get care
- Helping clients move easily through the system
- Establishing roles and responsibilities for programs
- Reshaping residential treatment services
- Making services more flexible
- Giving clients more choices in where and how services are delivered
- Responding to changing and more diverse client needs

2) **Improve how we monitor and evaluate services**

- Assessing the service mix and availability
- Evaluating treatments and their costs and health outcomes
- Encouraging continuous quality improvement
- Identifying research priorities

3) **Improve how we structure, plan and organize addiction services**

- Shifting from small, single focus agencies to an integrated multi-functional approach for service organization and delivery

The Ministry of Health and Long Term-Care instructed District Health Councils across the province to undertake a collaborative planning process to lead local communities toward new ways of meeting the challenges and pressures addiction treatment services face in 1999 and beyond. Local planning should lead to the development of:

- A shared vision for addiction treatment services in their communities
- Guiding goals and principles consistent with the directions established in Setting the Course
- Plans that will support the integration of addiction services through mergers, amalgamations and service agreements
- Priorities which will guide next steps and implementation of the integrated services plans

Integrated service plans for each district are to be submitted to the Ontario Substance Abuse Bureau.

1.2 Methodology

The Niagara District Health Council established the Substance Abuse Task Force in March 1999 to plan the rationalization of addiction services in Niagara. The task force was made up of six members. In addition, there were ex-officio members representing the Addiction Services Mobilizing Committee, the Centre for Addiction and Mental Health, the Ontario Substance Abuse Bureau, and the Niagara District Health Council. Copies of the Terms of Reference and Task Force membership are provided in Appendices A and B respectively.

The following steps have been or will be implemented by the Task Force:

Step 1: District Health Council staff met with Niagara Addiction Services Mobilizing Committee (ASMC) to establish communication links with the Task Force.

Step 2: Provincial and local background information was compiled and reviewed by Task Force members.

Step 3: An inventory of services for the Niagara addiction system was undertaken.

Step 4: A two-day workshop with addiction service providers and task force members took place in July to develop a Niagara system logic model.

Step 5: In July, eleven consumer focus groups were held across the Niagara region to solicit input on needs and gaps in addiction services. Additional comments were provided through questionnaires from clients of a St. Catharines methadone clinic. Approximately 100 individuals participated in this process.

A focus group for French speaking individuals was also held in November to solicit input on service requirements for this population in Niagara.

Step 6: A community consultation was held on the morning of September 10th for consumers, representatives of community health and social services organizations, and other referring agencies. Fifty individuals provided comments by answering questions relating to the rationalization initiative.

Step 7: An addiction service provider consultation was held in the afternoon of September 10th. Twenty-nine staff and board members attended.

Step 8: Task Force members met every two weeks from October to December to analyze consultation information, review "best advice papers" and determine what services should be delivered in the proposed new Niagara addiction system, how the services should be delivered and who should deliver those services. An implementation strategy was also developed.

Step 9: A draft report was prepared and sent out to the community for feedback and comments on December 13th. Written responses were requested by January 3rd, 2000. A community consultation was held on January 7th, 2000.

Step 10: Task Force members reviewed feedback/comments from community stakeholders and finalized the report.

Step 11: The Niagara District Health Council was asked to review the report prepared by the Substance Abuse Task Force and to release the final version to the community and to the Ministry of Health and Long-Term Care, Ontario Substance Abuse Bureau by January 20, 2000.

2 *PLANNING CONTEXT*

2.1 Environmental Scan

2.1.1 Geography

The Niagara region is an 1850.85 square kilometre area defined by its natural borders: Lake Ontario on the north, the Niagara River on the east and Lake Erie on the south. Only the western boundary is less well defined as it borders on farmland that extends into other political areas (Haldimand-Norfolk and Hamilton-Wentworth). Niagara contains twelve local municipalities: five cities, five towns and two townships. It is a mixture of urban areas, small towns and hamlets, and large agricultural rural areas. Geographic divisions, formed long before Niagara became a regional municipality, continue to influence the organisation and delivery of all human services.

2.1.2 Demographics

No single local municipality contains a majority of Niagara's residents. According to the 1996 census, the population of the Niagara region was 416,372, with 34% of residents living in St. Catharines, 19% in Niagara Falls and 12% in Welland. The remaining population lives in small towns and rural areas scattered across the region.

The local municipalities of Welland and Port Colborne are designated communities under the French Language Services Act.

Niagara's climate, location and geographic features make it attractive to older adults for retirement living. However, its long-term economic slowdown, coupled with its large agricultural sector, has contributed to a significant migration of younger persons from the area. As a consequence, Niagara has a large concentration of seniors. According to the 1996 census, persons age 65 and over constitute 15.6% of Niagara's population. This compares to the 1996 provincial average of 12.1%. It is estimated that by 2003, Niagara's population aged 75 and over will have grown 20% to 34,948 and the population aged 85 and over will have grown more than 26% to 8,325 people.

There are 335,048 individuals 15 years of age and over living in the Niagara region. See Table 1 for 1996 Census Canada population details.

TABLE 1
1996 CENSUS CANADA POPULATION FOR NIAGARA
(Gender and Age Breakdown)

NIAGARA						
Age	Male		Female		Total	
	Number	Percent %	Number	Percent %	Number	Percent %
0 – 4	13,254	6.5	12,723	6.0	25,977	6.2
5 – 9	14,438	7.1	13,593	6.4	28,031	6.7
10 – 14	14,149	7.0	13,167	6.2	27,316	6.6
15 – 19	13,886	6.8	13,028	6.1	26,914	6.5
20 – 29	27,243	13.4	26,786	12.6	54,029	13.0
30 – 44	47,672	23.4	49,157	23.1	96,829	23.3
45 – 54	26,031	12.8	26,447	12.4	52,478	12.6
55 – 64	19,122	9.4	20,554	9.6	39,676	9.5
65 – 74	17,683	8.7	21,071	9.9	38,754	9.3
75-84	8186	4.0	12,283	5.8	20,469	4.9
85+	1701	0.8	4198	2.0	5,899	1.4
Total	**203,365**	**99.9**	**213,007**	**100.1**	**416,372**	**100.0**

2.1.3 In-Need Population Estimate

Using the information from the Mental Health Supplement, Ontario Health Survey, it is estimated that the prevalence of lifetime substance abuse/dependence among the population of the Central West Region (Brant, Haldimand-Norfolk, Halton, Hamilton-Wentworth, Niagara, Waterloo and Wellington-Dufferin) aged 15 years and over is 14.9%. This prevalence rate is higher that the provincial average of 12.1%.

Relative to the average Central West Region need for addiction treatment services, Niagara is rated as "high". Niagara shows higher levels in the following categories:

- poverty;
- unemployment;
- smokers aged 11 – 25 smoking 25+ cigarettes per day;
- those drinking more than 2 drinks per day;
- 10+ drinks on a single occasion;
- those drinking/driving in past year;
- accidents with alcohol involved driver;

- alcohol related general hospital admissions;
- those who used illegal drugs 5+ times in life;
- used illegal drugs in past 12 months;
- drug related admissions to hospital and drug related mortality.

2.2 Key Niagara Service Delivery Challenges

- Maintaining and increasing quality and level of service within budget constraints.
- Increasing numbers of consumers with multiple, complex service requirements.
- Inadequate transportation system in the Niagara region, both within and between local municipalities.
- Under-resourced medical, psychiatric and community mental health services.
- Maintaining effective service links between addiction service providers and mental health service providers, health care providers and other community support agencies.
- Providing choice of addiction treatment services, as well as a range of addiction service approaches.
- Wage differentials among local addiction service agencies in Niagara.
- Providing services to clients whose first language is not English, including Francophones and other ethnic groups.

2.3 Overview of Niagara Addiction Treatment Services and Supports

The Niagara region is fortunate to have a broad continuum of addiction treatment supports and services. There are fifteen addiction agencies, service providers and consumer groups providing addiction treatment and/or support services utilising a variety of approaches. The range of services and supports include: assessment, case management, community treatment, community day/evening treatment, short-term residential treatment, residential detox, residential support services level 1 and 2 for men, residential support services level 2 for women, specialised treatment programs, such as methadone clinics, and a variety of self-help support groups such as AA, Gamblers Anonymous, and Labyrinth Group. Although a broad range of treatment approaches are available in Niagara, from an abstinence based 12 step model to harm reduction approaches including needle exchange and methadone clinics, individual agencies utilise a particular approach within each of their specific programs.

In 1998-99, the Ontario Substance Abuse Bureau provided $4,222,773 to six treatment agencies in Niagara. The remaining nine agencies received funds from other sources such as OHIP, fundraising, private donations, and/or other government departments.

2.3.1 Inventory of Services and Programs

Table 2 provides an overview of all current addiction programs and services in Niagara, indicating type of service, location of services, specialised programs and services for special populations. Definitions for the addiction treatment programs are provided in Appendix D.

Although Niagara does provide a wide range of services and programs, there are some identified gaps. The following services are not available in Niagara:

- Community medical/psychiatric treatment services (methadone clinics and basic partnership services only – see Appendix D.)
- Residential Medical /Psychiatric Treatment
- Community withdrawal management services levels 1, 2, 3
- Residential withdrawal management services level 3
- Residential support services level 1 for women.

Specialised addiction treatment programs are not available to the following populations:

- Francophones
- Ethnocultural
- Individuals with disabilities
- Gay, lesbians, bisexuals.

Withdrawal management services levels 1 and 2 are provided in St. Catharines and are identified as a regional service. As transportation is a major problem in the region, Niagara Detox does provide transportation assistance.

Appendix D provides a detailed program description of all Niagara addiction programs and services. The following information is included: service locations, admission criteria, number of clients served in 1998-99, full-time equivalents (FTEs), sources of revenue, service agreements and service approaches.

2.3.2 Addiction Services Mobilizing Committee

The Addiction Services Mobilizing Committee (ASMC), established in 1980 by the Addiction Research Foundation and the Niagara District Health Council, is the planning and coordination mechanism for the addiction system in Niagara. Currently there are eighteen members including executive directors of all six OSAB funded addiction treatment agencies, other Niagara addiction service providers, representatives from referring community agencies, other community stakeholders, and a representative from the Niagara District Health Council. Participation in the ASMC is voluntary; it is a network, without binding decision-making authority. The ASMC is a liaison committee to the Niagara District Health Council.

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TABLE 2
NIAGARA ADDICTION SERVICES/PROGRAMS *

			NADAS **	DETOX **	Branscombe House	Wayside House **	ARID Group	Alcohol & Drug Treatment Centre (Niagara) **	New Port Centre **	WARM	Fort Erie Native Friendship Centre***	AIDS Niagara	Alcoholics Anonymous	Gamblers Anonymous	Labrynth Group	Dr. George Davidson	Pt. Colborne Methadone Clinic
Addiction Treatment, Services and Supports		Entry	X	X				X	X	X							
		Initial Assessment/Treatment Plannings	X					X	X	X							
		Case Management	X					X	X	X	X						
		Community Treatment Services	X					X	X	X							
		Community Medical/Psychiatric Treatment Services	X						X							X	X
		Community Day/Evening Treatment Services						X	X								
		Residential Treatment Services							X								
		Residential Medical/Psychiatric Treatments															
		Residential Support Services Level I				X											
		Residential Support Services Level II			X		X										
		Community Withdrawal Management Services Level I															
		Community Withdrawal Management Services Level II															
		Community Withdrawal Management Services Level III															
		Residential Withdrawal Management Services Level I		X													
		Residential Withdrawal Management Services Level II		X					X								
		Residential Withdrawal Management Services Level III															
Niagara Addiction Services	Other	Self-Help/Peer Support		X	X					X			X	X	X		
		Outreach										X	X				
	Location	Fort Erie	X				X			X	X	X	X	X			
		Grimsby	X										X				
		Lincoln	X										X				
		Niagara Falls	X						X			X	X	X			
		Niagara-on-the-Lake															
		Pelham											X				
		Port Colborne	X						X	X		X	X				X
		St. Catharines	X	X	X	X		X	X			X	X	X	X	X	
		Thorold					X					X	X				
		Wainfleet															
		Welland	X						X	X		X	X		X		
		West Lincoln															
	Specialized Programs/Services	Youth (under 18)	X														
		Older Adults	X						X								
		Women		X	X			X	X	X							
		People with concurrent disorders	X					X	X								
		HIV Positive Individuals	X									X					
		Aboriginal people									X						
		Francophones															
		Ethnocultural communities															
		Homeless		X													
		Gay, lesbians, bisexuals															
		People with disabilities															
		People with acquired brain injuries		X				X									
		Problem gamblers	X											X			
		Families/Couples	X					X	X								
		Cocaine users							X								
		Eating Disorders							X								
		Methadone Clinic														X	X

* See Appendix D for program descriptions.

November 1999

** Funded by Ontario Substance Abuse Bureau, Ministry of Health and Long Term Care.

*** Funded by Ontario Substance Abuse Bureau, Ministry of Health and Long Term Care - native allocation.

TABLE 2
NIAGARA ADDICTION SERVICES/PROGRAMS *

		NADAS **	DETOX **	Branscombe House	Wayside House **	ARID Group	Alcohol & Drug Treatment Centre (Niagara) **	New Port Centre **	WARM	Fort Erie Native Friendship Centre***	AIDS Niagara	Alcoholics Anonymous	Gamblers Anonymous	Labrynth Group	Dr. George Davidson	Pt. Colborne Methadone Clinic
Addiction Treatment, Services and Supports	Entry	X	X				X	X	X							
	Initial Assessment/Treatment Plannings	X					X	X	X							
	Case Management	X					X	X	X	X						
	Community Treatment Services	X					X	X	X							
	Community Medical/Psychiatric Treatment Services	X						X							X	X
	Community Day/Evening Treatment Services						X	X								
	Residential Treatment Services							X								
	Residential Medical/Psychiatric Treatments															
	Residential Support Services Level I				X											
	Residential Support Services Level II			X		X										
	Community Withdrawal Management Services Level I															
	Community Withdrawal Management Services Level II															
	Community Withdrawal Management Services Level III															
	Residential Withdrawal Management Services Level I		X													
	Residential Withdrawal Management Services Level II		X					X								
	Residential Withdrawal Management Services Level III															
Niagara Addiction Services — Other	Self-Help/Peer Support		X	X					X			X	X	X		
	Outreach										X	X				
Niagara Addiction Services — Location	Fort Erie	X				X			X	X	X	X	X			
	Grimsby	X										X				
	Lincoln	X										X				
	Niagara Falls	X						X			X	X	X			
	Niagara-on-the-Lake															
	Pelham											X				
	Port Colborne	X						X	X		X	X				X
	St. Catharines	X	X	X	X		X	X			X	X	X	X	X	
	Thorold					X					X	X				
	Wainfleet															
	Welland	X						X	X		X	X		X		
	West Lincoln															
Niagara Addiction Services — Specialized Programs/Services	Youth (under 18)	X														
	Older Adults	X						X								
	Women		X	X			X	X	X							
	People with concurrent disorders	X					X	X								
	HIV Positive Individuals	X									X					
	Aboriginal people									X						
	Francophones															
	Ethnocultural communities															
	Homeless		X													
	Gay, lesbians, bisexuals															
	People with disabilities															
	People with acquired brain injuries		X				X									
	Problem gamblers	X											X			
	Families/Couples	X					X	X								
	Cocaine users							X								
	Eating Disorders							X								
	Methadone Clinic														X	X

November 1999

* See Appendix D for program descriptions

** Funded by Ontario Substance Abuse Bureau, Ministry of Health and Long Term Care

*** Funded by Ontario Substance Abuse Bureau, Ministry of Health and Long Term Care - native allocation

2.4 Overview Of OSAB Funded Addiction Treatment Services

Highlights:

- There are six OSAB funded addiction treatment programs in the region of Niagara.
- The majority of services are located in or in close proximity to St. Catharines, the largest city in Niagara.
- In the six-month period from April 1, 1998 to September 30, 1998, a total of 4,859 cases were opened.*
- A total of 1,966 individuals received addiction treatment service in Niagara during this six-month period: 1,670 individuals were residents of Niagara, 296 were non-residents.*
- Of the total 1,966 individuals, 1,260 individuals received non-residential services and 706 received residential services.*
- A total of 233 individuals identified as family members received service during this six-month period.*
- In 1998-99 the Niagara addiction system received a total allocation of $4,222,773 from the Ontario Substance Abuse Bureau, Ministry of Health and Long Term Care.

* ***Drug and Alcohol Treatment Information System, Provincial Report for Niagara DHC, April 1, 1998 to September 30, 1998.***

2.4.1 Profile of Services

The following profile provides information on the six OSAB funded addiction services by treatment option. Niagara is fortunate to have a wide range of treatment services located within the region. As indicated, these programs and services offer a broad range of treatment approaches, including abstinence and harm reduction, as well as a number of specialised programs targeted to specific populations.

TABLE 3
PROFILE OF ONTARIO SUBSTANCE ABUSE FUNDED
NIAGARA ADDICTION TREATMENT PROGRAMS

COMMUNITY TREATMENT SERVICES 1998 – 99	
Niagara Alcohol and Drug Assessment Service (NADAS)	
• Entry • Initial assessment • Treatment planning • Case management (on-going assessment) • Community Treatment Services • Community medical/psychiatric services (partnership) • Choices program for adults, youth and incarcerated males • Mobile outreach • Problem gambling program	• ***Range of treatment approaches*** • ***1649 assessment/planning clients (98/99)*** • ***539 community treatment clients*** • ***12 FTE's*** • ***$598,490 OSAB funding***
Alcohol and Drug Treatment Centre (Niagara)	
• Entry, treatment planning • Case management (on-going assessment) • Day treatment program • Early treatment, relapse prevention, aftercare • Anger management • Concurrent disorder brief counselling • Individual, couples, family and group counselling	• ***Range of treatment approaches*** • ***909 assessment/planning clients (98/99)*** • ***730 individual clients*** • ***7.7 FTE's*** • ***$345,187 OSAB funding***
New Port Centre	
• Case management (on-going assessment) • Community treatment services • Community medical/psychiatric services (partnership) • Eating disorder group • Harm reduction/methadone clinic (partnership) • Choices program for incarcerated males • Aftercare, recovery relapse prevention, outreach	• ***Range of treatment approaches*** • ***922 individuals (98/99)*** • ***6.79 FTE's*** • ***$ 270,000 OSAB funding (includes wages and benefits only, no other program costs)***
RESIDENTIAL WITHDRAWAL MANAGEMENT SERVICES	
Niagara Detox Centre (Department of the Hotel Dieu Hospital)	
• Entry • Intoxication and withdrawal management levels I and II • 22 beds male and 14 beds female	• ***Abstinence approach*** • ***1437 males and 664 females (98/99)*** • ***27 FTE's*** • ***$1,202,251 OSAB funding***

(table continued)

RESIDENTIAL SUPPORT SERVICES	
Wayside House Niagara	
• Men's residential support services Level I • 40 beds: 20 OSAB funded	• *12 Step approach* • *99 total individuals (98/99)* • *8.5 FTE's* • *86% OSAB funding $402,263*
Arid Group Homes (Niagara)	
• Men's residential transition support services level II • 16 beds	• *12 Step approach* • *54 individuals (98/99)* • *1 FTE* • *(27%) OSAB funding $37,619*
RESIDENTIAL TREATMENT SERVICES	
New Port Centre	
• 25 co-ed beds • 25 cocaine specific beds • 10 women's beds	• *Abstinence approach* • *584 total individuals (98/99)* • *20.49 FTE's* • *$1,366,963 OSAB funding*

2.4.2 Location of Services

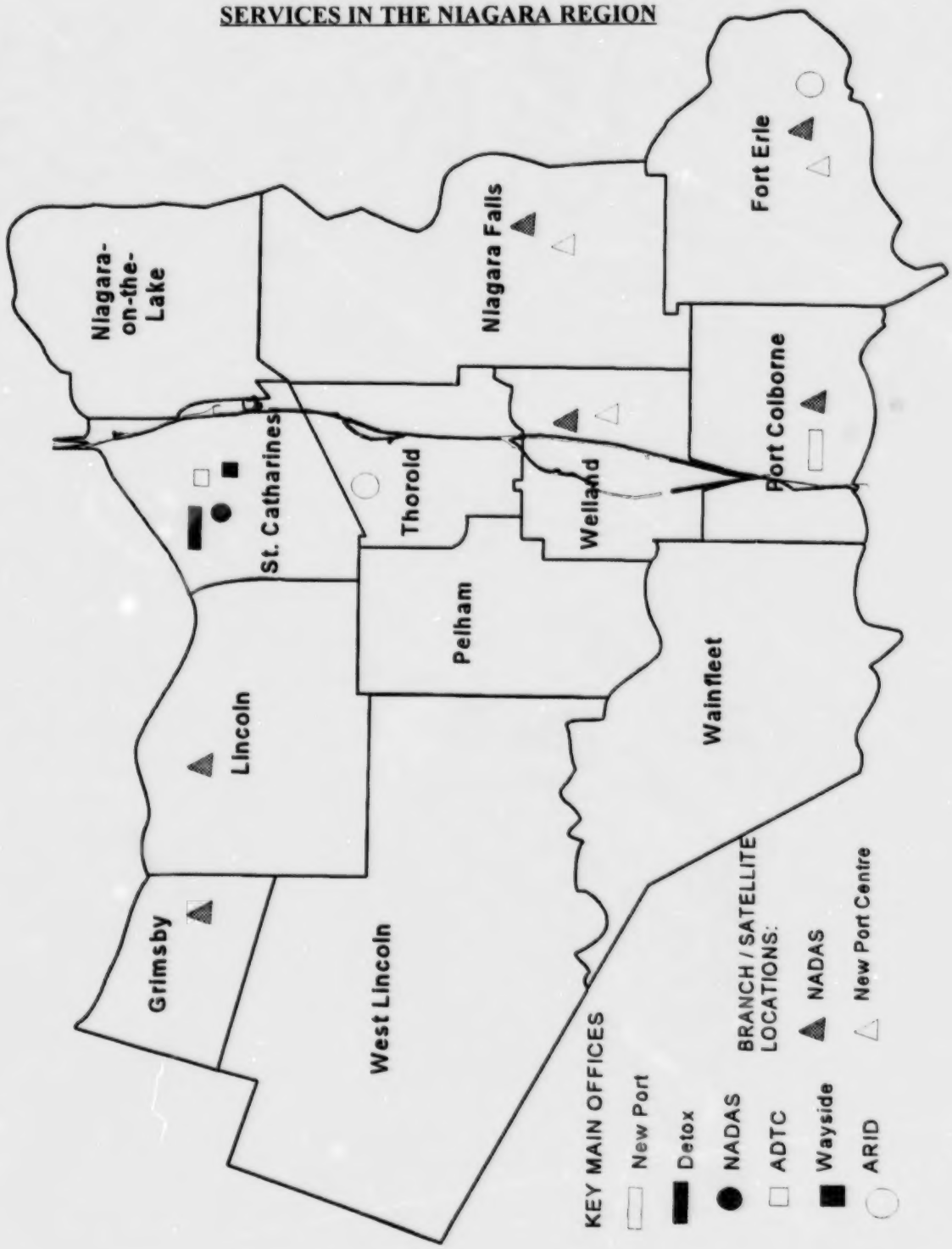
OSAB funded services are concentrated in St. Catharines, the largest populated municipality of the region, with New Port Centre for residential treatment services in the smaller community of Port Colborne located some distance away on Lake Erie. Branch or satellite services are provided in Grimsby, Lincoln, Niagara Falls, Welland, and Fort Erie. The western section of the region including Grimsby, West Lincoln, Lincoln, Pelham and Wainfleet are not well served. Map 1 illustrates the location of the services, including primary service locations and branch/satellite services.

2.4.3 Ontario Substance Abuse Bureau Allocation of Funds by Service Type

Addiction services provide non-residential or community services and programs and residential, or in-patient, treatment services.

Non-residential services are provided to individuals who reside in the community and not in a treatment facility. These services may include information and education, initial assessment and treatment planning, community treatment, day/evening treatment, aftercare, and family support, etc.

MAP 1
LOCATION OF ADDICTION TREATMENT
SERVICES IN THE NIAGARA REGION



Residential services are in-patient programs and are identified as regional programs, open to residents of Niagara, as well as individuals from outside the local district. With respect to the addiction rationalisation of services, a provincial working group is reviewing residential services in Ontario and will be completing recommendations relating to these services independent of this local review.

In Niagara the largest portion of OSAB funding is directed to residential programs and services. Table 4 provides a breakdown of OSAB funding by agency and by residential and community-based programs. New Port Centre funding is allocated to both residential and community-based programs and supports; the community-based program budget is an estimate based solely on wages and benefits, without operating costs.

TABLE 4
1997-98 BUDGET ALLOCATIONS FOR OSAB
FUNDED AGENCIES IN THE REGION OF NIAGARA BY
RESIDENTIAL PROGRAMS AND COMMUNITY-BASED PROGRAMS

OSAB Funded Programs	Residential Program Budget for 1998-99	Community-based Program Budget for 1998-99
Niagara Alcohol & Drug Assessment Service		$598,490
Alcohol & Drug Treatment Centre Niagara		345,187
New Port Centre	$1,366,963	270,000
Niagara Regional Women's and Men's Detox	1,202,251	
Arid Group Homes (Niagara)	37,619	
Wayside House of St. Catharines	402,263	
Total Budget	**$3,009,096**	**$1,213,677**
Percent of Total Budget	**71.26%**	**28.74%**

In comparing number of clients served in residential programs and community-based programs as a per cent of the total Niagara funding allocation from OSAB, the majority of funding (71.26%) is directed to residential services which provides programming to 20% of total individuals. See Table 5.

TABLE 5
NUMBER OF CLIENTS SERVED BY TYPE OF SERVICE AS A PERCENT OF TOTAL OSAB FUNDING DATIS INFORMATION:
SIX-MONTH PERIOD FROM APRIL 1 TO SEPTEMBER 30, 1998

	New Individuals	% of New Individuals	Per cent of Niagara OSAB allocation
All client types and all services	1,966 (296 Non-Niagara)	100%	100%
Withdrawal management: including family members	631	32% *	28.47%
Non-residential: Including family members	1,260	64% *	28.74%
All residential (including withdrawal management): Including family members	385	20% *	71.26%

* *Does not total 100% as clients may receive multiple services.*

2.4.4 Staffing, funding and governance of OSAB funded addiction treatment agencies in Niagara

Table 6 provides information relating to staffing, funding, services and governance issues.

Addiction agencies vary widely in staffing levels, salary scales, and budget expenditures. Staffing levels in the four smallest agencies range from 1 to 12 employees; the two largest agencies each have 27. Unions are involved in only one work site.

With respect to governance issues, four agencies are independent organisations with boards of directors and two are departments of area hospitals. All agencies are in leased premises except for the two residential support homes, which are owned.

In reviewing staffing levels and budgets, it is important to note that the addiction treatment system in Niagara has had to endure increasing financial pressures during the past decade. OSAB allocated $4,222,773 to Niagara addiction treatment services in 1998-99. This annual allocation has remained virtually unchanged since 1992. Taking into account increased operating expenses and inflation since that time, the addiction system has in fact realised a loss in operating revenue. In addition, agencies have had to manage rising caseload numbers, and more complex service requirements, placing increasing pressures on the staff of addiction agencies.

TABLE 6
STAFFING, FUNDING AND GOVERNANCE OF
OSAB FUNDED NIAGARA AGENCIES (1998-99)

	NADAS	ADTC	NEW PORT CENTRE	DETOX	WAYSIDE HOUSE	ARID
Director	1	.5	1	1	1	
A/Director						1
Supervisors/ Team Leaders	1.2	.5	1 & 3	1	1	
Counsellors	7.8	5.5	20.63	22.37	4	
Attendants						
Clerical	2	1.2	1.14	2	.75	
Other			.65	.5	.67 and 1.5	
Total FTE's	12	7.7	27.42	26.87 Includes 1 FTE-HDH	8.92	1
Union	N/A	N/A	N/A	CUPE	N/A	N/A
OSAB	$598,490	$345,187	$1,636,963	$1,202,251	$402,263 (86%)	$37,619 (27%)
Number of clients served 1998-99	1649 community out-patient treatment services	909 assessment 730 individual clients	922 outpatient 584 residential	Inpatient: 1437 males 664 females Outpatient: 1700 drop in	99 males	54 males
Service area	Niagara	Niagara	Ontario	Niagara	Niagara	Niagara
Services and Programs	Entry, initial assessment, treatment planning, Case management (on-going assessment), Outreach, problem gambling, Choices and various community outpatient programs.	Entry, treatment planning, case management (on-going assessment), community day/evening treatment, individual counselling.	Entry, case management (on-going assessment), residential treatment, community treatment, community psych/med services, eating disorders, methadone clinic, Choices.	Entry, men`s and women`s withdrawal management levels I and II	Men`s residential support level I	Men's residential support level II

	NADAS	ADTC	NEW PORT CENTRE	DETOX	WAYSIDE HOUSE	ARID
Physical Plant issues	Offices in St. Catharines, lease to 2004, and N.F., annual lease. Also satellite locations.	Office in St. Catharines. Lease terminates 2005.	Central office located in Port Colborne General Hospital. Also satellite locations. No lease.	St. Catharines	St. Catharines	Homes located in Fort Erie and Thorold.
Governance	Board of Directors	Board of Directors	Port Colborne Hospital Board of Directors	Hotel Dieu Hospital Board of Directors	Board of Directors	Board of Directors

3 NEEDS ASSESSMENT

3.1 Stakeholder Consultations

The Substance Abuse Task Force provided stakeholders in Niagara various opportunities to provide comments and input to the rationalisation process. In July 1999, eleven consumer focus groups were held in agencies across Niagara. Approximately 100 clients participated; they provided some excellent comments and suggestions. Questionnaires were also distributed through the methadone clinic; eighteen responses were received. A focus group for French-speaking individuals was also held. In addition, two separate consultations were hosted, one for members of the general community and one for staff and volunteers of local addiction service agencies. Fifty individuals attended the community consultation and twenty-nine attended the service provider consultation. Appendix E provides a summary of client comments. Appendix F includes a list of participants at the community consultation, a summary of comments and a summary of evaluations. Appendix G includes a list of participants at the service providers' consultation, a summary of comments and summary of evaluations. Appendix H lists participants of the focus group for French-speaking residents of Niagara.

3.2 Common Themes

The following section identifies common themes that emerged from the input provided at the various client focus groups and the stakeholder consultations including accessibility, gaps in service, quality of service and system integration.

3.2.1 Accessibility

Clients raised a number of concerns relating to accessibility.

- They did not know what addiction treatment programs and services were available in Niagara and thought the programs were not well promoted.
- They said health care providers needed education and training on addiction issues to be able to identify individuals at risk and to make appropriate referrals.
- Closer links with other services were needed, e.g., physicians and mental health services.
- Transportation was identified as a major barrier in the Niagara region in accessing services.
- Some suggested services should be provided across the region to improve access for clients that do not have transportation.
- They also thought there was a need for more flexible hours and weekend services.
- Wait lists, understaffing, and inflexible agency policies also limited access for some clients.

Participants at the community consultation identified similar access issues.

- They indicated a need for one point of entry; centralised access to information was identified.
- Transportation and childcare barriers limited access.
- Services were not available across the region.
- The waiting list for the methadone clinic in St. Catharines was a problem.
- Shortage of physicians was a problem.
- There is a need for more community education and outreach.

Service providers thought that accessibility to programs in general was good, however they did identify the following needs.

- Niagara needs more methadone programs, psychiatrists, physicians and other specific programs such as anger control services.
- Issues relating to resources and government commitment were identified as problems and contributed to gaps in service.
- More networking between staff members of the various agencies was suggested, as some staff members were not aware of all programs available at other addiction treatment agencies.
- Transportation, childcare, lack of information on services, and waiting lists or perception of waiting lists also created barriers for clients.

3.2.2 Gaps in Service

Clients identified the following service needs:

- A halfway house for women;
- More transitional housing;
- More community education and outreach programs;
- Self-help groups that are not 12 step;
- Enhanced opportunities to socialise in safe places;
- A 24-hour drop in centre; and
- A medical detox.

Community stakeholders identified the following gaps in service:

- After-care in remote areas;
- Services for individuals with concurrent disorders, methadone clinics, services for youth, seniors, mandated clients, low-threshold clients, and acquired-brain injury clients;
- A recovery home for women;
- Supportive housing;
- Family services; and
- More staff resources.

Service providers identified many similar gaps in service. These included:

- A women's residential recovery home;

- Services for youth, seniors, families, correction clients, clients with a concurrent disorder, clients with eating disorders, and clients with disabilities;
- Outreach services;
- A women's drop-in centre;
- Pre-treatment and after-care services; and
- Alternatives for housing.

3.2.3 Quality of Service

Clients, in general, described their experiences within the addiction treatment services in Niagara as positive. They thought staff were caring, responsive and knowledgeable, and that as clients, they were treated with respect and made to feel comfortable. They thought they were able to make their own choices and decisions. Clients did suggest that more individualised care was needed, and that insufficient funding resulted in staffing problems and staff turnover, which affected the quality of service.

Community stakeholders thought the following suggestions could improve quality of service:
- More resources to provide more support workers and treatment services;
- Improved communication links between other community agencies, including referring agencies and health care providers, and addiction service providers;
- Improved case management services for clients;
- More collaboration and cooperation between addiction service providers and less agency ownership;
- A better approach for hard-to-serve clients;
- More consumer involvement; and
- More staff training and development.

Service providers provided the following comments with respect to quality of service.
- There is a need for standardised assessment, early identification, and standardised evaluation tools.
- There is a need for medical and psychiatric assessments to assist in treatment planning.
- A lack of government commitment and financing has had a negative impact on the quality of service, resulting in an under-resourced system.
- There is a need for more staff training and development.
- Low salaries have resulted in high staff turnover.

3.2.4 System Integration

Clients generally commented that the agencies worked well together, but stated there was insufficient coordination between mental health and addictions services.

Community consultation participants identified the following:
- There was a need to improve coordination, integration and communication links between addiction service providers, health care providers and mental health services.

- There was also a need for more collaboration between addiction agencies and less bias with respect to treatment approaches.
- It was suggested that a variety of treatment modalities should be available from the same provider.
- Comprehensive case management services are needed with a more seamless system, centralised access, and standardised assessment tools and assessment/discharge criteria.
- Cross-discipline treatment teams to treat physical and mental health needs of clients.
- A single structure to manage/coordinate the system and more involvement of front-line staff members on decision-making committees were also suggested.

Staff and volunteers from addiction treatment services provided the following comments.

- There is a need for more networking within the system.
- Establishing formalised links among systems and agencies, a common database, a triage system and professional advisory groups would also increase system integration.
- It was suggested that Addictions Services Mobilizing Committee assume a planning and accountability role for the system, endeavour to provide consistency in employment policies, and investigate other efficiency measures within the system.
- More staff training and education were needed, and a comprehensive case management system.

4 *INTEGRATED SERVICE PLAN FOR NIAGARA REGION*

4.1 System Vision, Goals and Principles

The Substance Abuse Task Force reviewed and accepted the system vision, goals and principles as described in "**Setting the Course**".

Vision	**Goals**
All people in Ontario with an addiction problem will have access to an integrated, client-focused system of evidence-based, cost effective services designed to meet their diverse needs as well as the needs of family members and others affected by someone's addiction. ***The system exists to meet the needs of people with addictions, who are the focus of the system. The system will continually evolve and adapt, to reflect new knowledge, changing client needs, and changes in the broader health and social service system.***	To ensure that each district of the province offers an appropriate range of addiction services and has access to specialised programs in other parts of the province. To ensure that clients have access to appropriate addiction services and, in particular, to ensure that more people have access to services now in short supply. To ensure that clients move easily from one part of the system to another. To ensure that research knowledge is transferred into practice and used to shape treatment programs. To make the most effective use of the resources available for addiction treatment. To develop an integrated system of services that functions efficiently and effectively. To encourage individual services to work as part of an integrated, client-focused system to develop a multi-functional approach to the services they provide. To clearly identify the roles and responsibilities of addiction services in the addiction system, the services they provide and the clients they serve.
Principles **For clients:** ▪ Clients have the right to receive efficient, effective services. ▪ Clients and families will be actively involved in determining their own recovery and care.	▪ Clients will be assessed and offered the least intrusive intervention that is most likely to help them regain their health. ▪ Clients will receive care as close as possible to their homes ▪ Clients will have access to range of programs, philosophies and approaches, which reflect their diverse needs.

For addiction services: • Addiction services in Ontario will be based on the best available knowledge and research. • Addiction services in Ontario will be innovative. • The addiction services in a community will offer a range of treatment approaches and give clients a choice of treatment options that best suit them and their life experiences. The relationship among programs and agencies will be based on mutual respect for different approaches and philosophies.	• Addiction services are accountable to their clients, their communities and government for the quality of care they provide and for the efficient, effective use of their resources. • Addiction agencies will have a clearly defined role in the addiction service system and will be accountable to the broader addiction service system for fulfilling their defined role. • Addiction services are part of the broader health and social service system and will develop effective working partnerships with other sectors whose services could benefit their clients.
For the addiction service system: • The system exists to meet the needs of people with addictions, who are clients of the system rather than clients of individual agencies. • The system will build on the strengths of Ontario's addiction treatment services including their knowledge base, values, experience and tradition of volunteerism.	• The system will be flexible enough to meet the needs of the large numbers of people living in large urban centres as well as the smaller numbers of people living in rural and less populated parts of the province. • The system will develop specialised programs to meet the needs of underserved populations and to fill gaps in service. • The system will be developed by using existing resources more effectively. • Every effort will be made to shift funding from administration and overhead to service delivery.

4.2 Community Feedback

In considering how to improve the delivery of addiction treatment services in Niagara, the Task Force attempted to involve as many stakeholders as possible through the various focus groups and three consultations. Input from addiction treatment agencies was provided by the chair of the Addiction Services Mobilizing Committee, in her capacity as an ex-officio member of the Task Force.

In addition to community input, Task Force members reviewed various reports. These included the best advice papers contained in **"Rationalisation Project: Guidelines For Restructuring Services"** (October 1996), **"Addiction Treatment Services Restructuring in Central West Region: Final Report to the Ontario Substance Abuse Bureau"** (April 1997), and **"Niagara's Community Feedback"** (August 1997).

A "draft" report: **"Integrated Addiction Treatment Service Plan for Niagara"** was prepared and distributed to the community in December for their response and input. Stakeholders were invited to respond to the "draft" report by providing written comments or by attending a community consultation at the Ramada Parkway, St. Catharines on January 7th, 2000.

Nine written responses were received by the Task Force including comments from the Addiction Services Mobilizing Committee. There was support in principle for the recommendation to establish an addiction treatment coordinating network, as well as various suggestions to change other

recommendations. A number of agencies requested more time to provide comments; the Chair of the Task Force informed those agencies that additional feedback would be welcomed. A summary of the written responses is contained in Appendix K.

Forty-five individuals, including addiction service providers, consumers, representatives of various Niagara community social agencies and mental health services, Task Force members and DHC staff, attended the community consultation on January 7th to provide feedback to the "draft" report. See Appendix K for a list of participants.

Consultation participants expressed concern that the tight deadlines did not allow some individuals and boards of directors sufficient time to prepare a response to the "draft" report or to attend the consultation. DHC staff indicted that additional written comments/feedback could be submitted after the consultation and also sent to OSAB for their consideration.

Working in small groups, participants at the consultation discussed the "draft" report and the recommendations. Groups then provided their feedback to the larger forum. Participants were asked to indicate their support for the recommendations, to provide any suggestions for amendments, and to suggest any additional recommendations. A summary of the comments provided by the three small work groups is contained in Appendix K.

Consultation participants expressed the greatest concern with recommendations pertaining to the Addiction Treatment Network of Niagara (ATNN). Although there was support in principle for a planning, coordinating body for the system, concerns centred on the ATNN's mandate, scope of authority, membership, its relationship with the DHC and OSAB, and the impact on authority of individual addiction treatment agencies. Task Force members responded to the concerns by recommending that a six-month interim board be established with representation from the addiction treatment agencies and other community organizations to establish the network.

Participants indicated mixed support for the remaining recommendations. Many expressed concerns about implementing changes without a thorough needs assessment of the Niagara addiction treatment system in order to determine the scope for change, and to assist in establishing priorities. Given the scarcity of resources, they emphasized the need to perform a cost/benefit analysis and to prioritize the recommendations. Task Force members responded to the concerns and amended recommendations, as necessary, to include additional levels of review and analysis.

With respect to the recommendation to merge the community-based addiction treatment programs and services, stakeholders suggested that before any mergers take place, an in-depth cost/benefit analysis be completed to determine the impact on current and future resources. They also suggested that other horizontal and vertical linkages and structures be examined to determine the feasibility of other program links/amalgamations, for example, with mental health services. Task Force members responded to this feedback by encouraging ATNN to priority rank Task Force recommendations and undertake more detailed reviews/needs assessments and cost/benefit analysis as deemed necessary.

Some consultation participants expressed concerned with the level of addition treatment services for special populations in Niagara. In particular, it was suggested that additional services are needed for seniors, women, youth and individuals with concurrent diagnosis. The Task Force recommended a needs analysis be performed to prioritize services for target group populations.

Stakeholders also repeatedly mentioned the need for a thorough review and examination by OSAB of budget allocations for addiction services in Niagara. Grave concerns were raised regarding the ability of agencies to meet increasing financial pressures for pay equity obligations, increased rent and supply costs, increased benefit costs and union settlements with wage increases. It was repeated that unless additional financial supports are provided to the addiction system, services to clients would be affected.

4.3 Improving How We Deliver Services

The broad continuum of services that will be available in the Niagara addiction treatment system is illustrated in a system logic model. See Appendix I. Members of the Substance Abuse Task Force, executive directors of the six OSAB funded addiction agencies, as well as representatives from other Niagara addiction treatment services, developed the logic model during a two-day workshop. The diagram describes Niagara's six main components of service, and nine sub-components of treatment. Current and developmental process objectives and outcome objectives are included.

In developing an integrated service plan for addiction treatment services in Niagara, Task Force members first identified gaps in service within each component of the system logic model and then developed recommendations to address those needs. Current service agreements and partnerships were also examined. See Appendix J. The overall addiction system was then reviewed and recommendations relating to structure and governance were formulated.

4.3.1 System Integration and Coordination

Niagara stakeholders, including clients, addiction treatment service providers and other community members, stated there was a need for more integration, coordination, cooperation and system planning in the current addiction system. The current Addictions Services Mobilizing Committee has assumed a planning and coordinating role for the Niagara system over the past number of years. However, as a voluntary committee without legitimized decision-making authority, overall system planning has been compromised.

A central coordination committee, Addiction Treatment Network of Niagara (ATNN)*, with authority to plan and coordinate addiction treatment services in Niagara is needed. This committee would be authorized and supported by the Ontario Substance Abuse Bureau; the

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* Addiction Treatment Network of Niagara (ATNN) should be considered a working name of the central coordinating committee and can be changed if desired.

scope of authority will be developed by an interim board with discussion/negotiations with all addiction service providers in Niagara. The functions of the coordination committee would be guided by terms of reference and could include such tasks as: monitoring and evaluating system operations, including system capacity to meet the needs of increasing numbers of complex-needs clients; identifying system-wide staff training and development needs; developing training packages and establishing an on-going integrated approach to training; reviewing annual agency operating plans and new program proposals including budget allocations while considering overall system needs and gaps; submitting a system operating plan to the District Health Council (as opposed to individual operating plans) for review and comment as required by OSAB; and completing more detailed assessments to identify gaps and priorities within the local addiction treatment system. It is recommended:

1. That the Addiction Treatment Network of Niagara (ATNN), be formed in the near future to replace the current Addiction Services Mobilizing Committee, to be accountable to and endorsed by the Ontario Substance Abuse Bureau (OSAB), Ministry of Health and Long-Term Care, with the following scope of authority and areas of responsibility:

    - ensure needs assessments are performed as required, to prioritize recommendations of the Niagara Substance Abuse Task Force and to monitor the implementation of those priority recommendations;
    - engage in system planning;
    - facilitate collaboration and integration in the delivery of substance abuse services by member organizations;
    - promote evidence-based programs; and
    - foster coordination of addiction services with other community services in Niagara, including health care, mental health and social services.

Implementation

Recognizing the need to include community involvement, the complexity of the task and the volume of work involved in establishing a central coordinating committee such as the ATNN, it is recommended:

2. That a six-month interim board be established with two representatives from each OSAB-funded addiction treatment agency, as well as broad-based community membership, to oversee the development of the ATNN, with tasks including, but not limited to: hiring a staff coordinator to provide administrative support to the work of the interim board as well as the future ATNN; developing terms of reference and a workplan for the ATNN; and generally overseeing the development of the ATNN to a fully functioning network.

The Task Force suggests that the ability to determine priority ranking of Task Force recommendations would be facilitated by a system wide electronic database. Acknowledging the future need for permanent staff support for the ATNN, and as transitional funding is

currently available from OSAB to provide financial resources for the implementation of integrated treatment service plans, it is recommended:

3. That the interim board access one-time transitional funding from OSAB, with the NDHC serving as the flow-through agency, to establish the ATTN, support a staff coordinator for a period of two years, purchase computer hardware for addiction treatment service providers if required, and set up a Niagara addiction treatment system electronic database/client file compatible with the mental health system.

With continued emphasis on system planning and coordination, the Task Force encourages the ATNN to complete needs assessments and cost benefit analyses, as necessary, and thereby establish implementation priorities for the remaining Task Force recommendations.

4.3.2 Education/Health Promotion and Social Marketing/Fundraising

The Task Force encourages enhanced activities in the areas of education, health promotion and social marketing within the general community and especially in all local schools. This could be accomplished through: increased collaboration with various community partners such as the Public Health Department of the Regional Municipality of Niagara, and Information Niagara; soliciting corporate sponsorship for special projects; and increased use of technology. The Task Force recommends:

4. That ATNN take the lead to identify community training and information needs and develop a coordinated, consistent approach to community education, social marketing and fund-raising activities across the addiction treatment system.

4.3.3 Entry, Initial Assessment/Treatment Planning and Case Management

How capacity of the system has been or will be increased.

Service providers in Niagara have worked diligently to increase capacity of the system and have incorporated a number of changes to improve capacity. There are numerous examples within the Niagara system. The New Port Centre residential program has reduced the length of program stay from 28 days to 21 days. NADAS has increased the number of assessments completed in 1998-99 by 25% and individual counselling sessions by 65%, has consolidated youth and adult intake under a centralised system, and has established a walk-in clinic. And most agencies have increased group counselling services.

Consumers, service providers and community stakeholders all commented on the need for more coordination and collaboration within the addiction treatment system. A centralized access service was suggested by some to assist clients in entering the system, as well as a 1-800 number and centralized data collection, including an electronic client file.

To this end, the addiction agencies have recently joined the mental health system to investigate the feasibility of establishing a central access/regional information system in the region. Niagara Partners in Service, a coalition of community service providers, received one-time funding in the amount of $125,000 from the Ministry of Health and Long-Term Care to contract with the Centre for Addiction and Mental Health to complete an assessment. It is recommended:

5. That ATNN investigate the feasibility of establishing centralised access (perhaps integrated with the mental health system in Niagara), a 1-800 number for the region of Niagara and centralised data collection which would be compatible with other addiction treatment systems.

How client access to services has been or will be made easier and more accessible.

Addiction service providers have made efforts to reduce barriers to service by having inclusive admission practices, e.g., accepting clients on medication, with outstanding legal charges, and by modifying services where feasible for special needs clients. In addition, as transportation is a major barrier to accessing services in Niagara, efforts have been made to deliver services in satellite locations, and to provide taxi chits and bus fare to clients. Various partnership arrangements and service agreements have also been developed. See Appendix J.

Task Force recommendations are all directed to increase client access to services.

How clients will enter the addiction system, how assessment information will be shared between agencies and programs and how client needs will be managed during their recovery.

Currently clients access treatment services at any point within the continuum of services. Agencies accept referrals directly from within the system and rarely require re-assessment of the client unless a significant period of time has elapsed.

The role of case management as defined in Provincial Service Definitions is not fully in place in the Niagara system. Currently a case manager is assigned to each client, however, the full range of supports is not provided. Benchmarks for case management services do not exist. More intensive case management for high needs clients and special populations will require additional resources. In the area of clinical follow-up, currently aftercare services are available in most urban areas of Niagara. It is recommended:

6. That ATNN establish case management benchmarks for Niagara addiction treatment system.

7. That a system-wide case management service be established which incorporates identification of a primary worker (case manager); use of an electronic client file; and access to information from across the addiction system.

How the district will implement the standard assessment protocols and how this will change current practices.

OSAB must ensure the provision of training on the standard assessment protocols to all staff members before implementation can proceed. All addiction treatment agencies should implement the standard assessment protocols.

How the district will introduce the standard admission and discharge criteria and the steps it will take to ensure the criteria are used consistently.

Executive directors have received orientation to the admission and discharge criteria. OSAB must assume the responsibility to provide adequate and timely training to all staff. It is recommended:

8. That OSAB continue to provide training for addiction treatment service agencies in order to implement the standard assessment protocols and standardised admission and discharge criteria, and to provide this training to other relevant community stakeholders as required.

4.3.4 Treatment Services

In examining and analysing the addiction treatment system in Niagara, the Task Force identified the need to improve the quality of service to clients, to reduce duplication of services, and to ensure clients are offered a full range of treatment options. Following the Ministry's vision and goal to adopt an integrated, multifunctional approach to addiction treatment services, it is recommended:

9. That ATNN complete a thorough study including a cost/benefit analysis to provide direction in proposing internal and/or external service linkages, affiliations and/or mergers of various addiction treatment programs.

Withdrawal Management Levels 1, 2, 3

Efforts to develop and enhance withdrawal management services including outreach, in-home and rural initiatives.

Niagara is fortunate to have withdrawal management level 1 and 2 services available in the region. A need for level 3 services has been identified and, following best advice papers, a need to increase community withdrawal support systems. The impact of hospital restructuring, including the establishment of the new Niagara Health System and changes in services at the Hotel Dieu Hospital, on the delivery of withdrawal management services at Niagara Detox must be examined. It is recommended:

10. That ATNN determine if there is a need to expand community withdrawal management services across the region of Niagara.

11. That ATNN negotiate with the new Niagara Health System to dedicate four acute care beds to level 3 withdrawal management treatment services.

Community and Residential Medical/Psychiatric Treatment

Stakeholders identified a critical need for medical and psychiatric treatment services for clients accessing outpatient and residential addiction treatment services in the region. It is recommended:

12. That protocols of service be developed with the new Niagara Health System, Hotel Dieu Hospital, local physicians, psychiatrists, psychologists and other health care and community mental health service providers to provide medical health care assessments and treatment services, and mental health supports and services, including psychiatric assessments and treatment services, to individuals accessing addiction treatment.

Residential Support Level 1 and 2

The Niagara addiction treatment system currently has two residential support services for men. Branscombe House, a level 2 service supported by a private foundation, provides six beds for women in recovery. Residential support level 1 services are not currently available to women in Niagara. The Task Force endorses previous planning recommendations in identifying the need for a recovery home for women. It is recommended:

13. That ATNN determine the current demand for level 1 residential support services for women, and if warranted, apply for funding from OSAB to establish such services.

14. That ATNN establish residential housing and support benchmarks for Niagara.

4.3.5 Harm Reduction Programs

How the district will integrate harm reduction strategies into its services and the variety of harm reduction programs that will be available.

Harm reduction approaches are available within the addiction system in Niagara. However, a number of clients and addiction treatment service providers stated that all agencies do not provide unbiased information on harm reduction programs. Education is needed both for staff of addiction treatment agencies and the general community to ensure clients are provided with information on all treatment options, and have access to programs and services that follow evidence-based research.

How the district will provide access to methadone treatment and support for individuals requesting help for opiate dependency.

Methadone clinics are available in St. Catharines and Port Colborne. An additional service is being considered for St. Catharines. A general practitioner in the area has also expressed an interest in expanding his practice in addiction treatment. It is recommended:

15. That ATNN review the need to increase methadone services in the Niagara region.

4.3.6 Services for Special Populations

A strategy and plan for implementing French language services if identified as a designated area.

At the present time, the Francophone community was aware of only one French-speaking addictions worker in Niagara (located at the New Port Centre). Addiction service providers (including New Port Centre) report that they experience little demand for services in French. Participants at the French language focus group agreed that one reason for this lack of demand might well be that people do not tend to ask for services that they perceive to not exist. The Centre de Santé Communautaire is clearly perceived as a "Francophone agency" and is thought of as a hub of Francophone services in Niagara.

To meet the needs of French-speaking population of Niagara, it is recommended:

16. That community outpatient treatment and outreach services be provided by a French-speaking worker from the outpatient treatment service agencies, as needed, at the Centre de Santé Communautaire in Welland.

17. That supported community withdrawal or medical withdrawal be explored as an option for French-speaking detox clients through the needs assessment to be performed by the ATNN.

18. That OSAB, in consultation with the ATNN, establish a residential treatment service for French-speaking individuals located in the southern part of the province (Central East, Central West, Central South and South West, Ontario).

The treatment needs of identified special populations in the district and how the service system will meet their needs.

A multi-dimensional approach by the Niagara addiction system is required to improve access and flexibility to meet the needs of diverse special populations. This approach must consider the following dimensions or levels:

System Inclusiveness which requires the inclusion of diverse points of view from within and outside the formal addiction system in the development of system and agency policies, programs and procedures.

Outreach and Linkages, which are intended to proactively engage clients not traditionally well, served by addiction services, and to build relationships with other organisations to assist in the management of complex health and social needs that cannot be met solely by addiction treatment services. Relationships must be built with organisations dedicated to serving special populations, generic services and social networks. Communication strategies must also be developed.

Diverse Treatment Approaches which address how treatment interventions can be aligned with and account for the special needs of each group. These interventions must recognise the environmental factors that may affect the ability to seek help and manage addictions.

It is recognised that there will be limitations on both the number of linkages and diverse treatment approaches that can be meaningfully developed within the current resource base. Selecting priority population groups to be addressed over the next few years must take into account the size of a particular population/community, the resources currently available to meet the needs, and existing or emerging activities and organisations in other human service areas which would enhance the likelihood of successful intervention. It is recommended:

19. That ATNN determine service needs for special populations in Niagara with particular attention to youth, seniors, women and individuals with concurrent disorders.

4.3.7 Choice of Treatment Options

How the district will ensure that clients have a choice of treatment approaches, philosophies and modalities: the options available to clients; any service inequities and steps to be taken to address imbalances; service capacity (number of abstinence-based, community-based services) for each treatment option.

Task Force recommendations address the issue of client choice.

4.4 Improving How We Monitor and Evaluate Services

Local reports are required to describe: current evaluation strategies, tools and information sources used to measure the achievement of goals, objectives and outcomes; how research and evaluation findings have been and will be used to shape service/program design; and the way services will be monitored and evaluated in the future.

4.4.1 Current Evaluation and Monitoring Practices

The four addiction treatment agencies – NADAS, Alcohol & Drug Treatment Centre, Niagara Detox and New Port Centre have participated in workshops to develop agency program logic models which identify service components, goals and objectives and gaps in service.

In their annual operating plans, agencies report primarily process evaluation information, such as client satisfaction results measured through surveys and questionnaires, program utilization and client participation rates. Outcome evaluation to assess individual program or system-wide results is not being fully performed at this time.

All agencies provide information to the Drug and Alcohol Registry of Treatment (DART) and the Drug and Alcohol Treatment Information System (DATIS). Agencies suggested that information provided by these systems has not always been reliable, however it is improving.

4.4.2 Use of Research and Evaluation Findings/Results

Niagara addiction treatment agencies have responded to evidence-based research and "best practice" information. For example, a 21-day residential care program has been implemented in New Port Centre, and various harm reduction services have been established, including a needle exchange program and two methadone clinics. All Task Force recommendations support the continued implementation of evidence-based research findings.

4.4.3 How We Will Monitor and Evaluate Services in the Future

In order to ensure quality programs and services are delivered that meet the changing needs of clients, continuous monitoring and evaluation is suggested. The Substance Abuse Task Force encourages addiction treatment agencies to continue to concentrate on process evaluation by monitoring clients as they move through the Niagara treatment system, to keep up with broader-based research and evaluation on client outcomes, to participate in such research as appropriate and to continue to participate in the provincial data information systems, DART and DATIS.

It is expected that the new Addiction Treatment Network of Niagara will monitor and evaluate services on a system-wide basis. A system electronic database and electronic client file will greatly enhance the ability of ATNN to perform this task.

5 *COST SAVINGS AND RECOMMENDATIONS FOR RE-INVESTMENT*

It is not anticipated that any cost savings will be realised from the rationalisation of services as further study is required. In fact, substantial additional funding may be required depending on the outcome of more detailed analyses.

6 *IDENTIFICATION OF ADDITIONAL SERVICE PRIORITIES*

Given the continued under-funding of the addiction treatment system by OSAB (budgets have been frozen since 1992), Substance Abuse Task Force members are greatly concerned that addiction treatment services in Niagara, as well as across the province, will be soon compromised. Members believe that additional resources must be immediately invested to address the gaps and stresses in the system. The edict of doing more with less has already been accomplished and soon existing strains, including the lack of funds to meet pay equity obligations, rent and supply increases, and union wage settlements, will force agencies to decrease services to clients in our region. As agencies do not have the financial resources to meet some of these current obligations, OSAB is urged to respond to this critical situation as soon as possible. Task Force members suggest that an investment in the addiction system would free up additional resources in the province, by reducing spiraling costs to the health care system, the criminal justice system and other community support services. It is recommended:

20. That OSAB immediately undertake a provincial budgetary review of OSAB funded programs including a full review of staff salary and benefit levels.

The recommendations detailed in this report are about integrating addiction treatment services to improve services to clients, and using resources in the most cost-effective way. Some recommendations can be accomplished within existing allocations, however, some require one-time transitional funding and others will require funding for capital expenditures and on-going operating expenses.

6.1 Transitional Funding

One recommendation, Recommendation #3, will require one-time transitional funding from OSAB:

3. That the interim board access one-time transitional funding from OSAB, with the NDHC serving as the flow-through agency, to establish the ATTN, support a staff coordinator for a period of two years, purchase computer hardware for addiction treatment service providers if required, and set up a Niagara addiction treatment system electronic database/client file compatible with the mental health system.

6.2 Funding for Capital and/or Ongoing Funding for Operating Expenses

The Task Force encourages the ATNN to complete more in-depth assessment and cost/benefit analyses to determine priority ranking of the indicated recommendations. Depending the outcome of further analyses, the following eleven recommendations may require on-going funding from OSAB:

5. That ATNN investigate the feasibility of establishing centralised access (perhaps integrated with the mental health system in Niagara), a 1-800 number for the region of Niagara and centralised data collection which would be compatible with other addiction treatment systems.

7. That a system-wide case management service be established which incorporates identification of a primary worker (case manager); use of an electronic client file; and access to information from across the addiction system.

8. That OSAB continue to provide training for addiction treatment service agencies in order to implement the standard assessment protocols and standardised admission and discharge criteria, and to provide this training to other relevant community stakeholders as required.

9. That ATNN complete a thorough study including a cost/benefit analysis to provide direction in proposing internal and/or external service linkages, affiliations and/or mergers of various addiction treatment programs.

10. That ATNN determine if there is a need to expand community withdrawal management services across the region of Niagara.

13. That ATNN determine the current demand for level 1 residential support services for women, and if warranted, apply for funding from OSAB to establish such services.

15. That ATNN review the need to increase methadone services in the Niagara region.

16. That community outpatient treatment and outreach services be provided by a French-speaking worker from the outpatient treatment service agencies, as needed, at the Centre de Santé Communautaire in Welland.

17. That supported community withdrawal or medical withdrawal be explored as an option for French-speaking detox clients through the needs assessment to be performed by the ATNN.

18. That OSAB, in consultation with the ATNN, establish a residential treatment service for French-speaking individuals located in the southern part of the province (Central East, Central West, Central South and South West, Ontario).

19. That ATNN determine service needs for special populations in Niagara with particular attention to youth, seniors, women and individuals with concurrent disorders.

7 IMPLEMENTATION STRATEGIES AND TARGETS

The following strategies and targets were developed to implement the recommendations of the Substance Abuse Task Force.

7.1 Role of the Niagara District Health Council

Task Force members expressed a need to have the Niagara District Health Council assume a more active role in working with the addiction system in Niagara and in particular, to initiate the implementation of Task Force recommendations. It is recommended:

21. That the Niagara District Health Council approve the appointment of a NDHC staff member in an ex-officio capacity on ATNN.

22. That the ATNN review individual addiction agency operating plans from a system perspective, provide feedback to the agencies on the review, and forward a system operating plan to the District Health Council, in their role to provide advice to the Ministry of Health and Long-Term Care.

7.2 Role of the Addiction Treatment Network of Niagara

In its role as system coordinator, the Addiction Treatment Network of Niagara will have the responsibility to ensure all Task Force recommendations are implemented in a timely manner.

The following targets are provided as a guide to the Network.

IMPLEMENTATION TARGETS	
Target 1	**March 2000** Interim board is established and immediately applies to OSAB for one-time transitional funding.
Target 2	**June 2000** Coordinator is hired.
Target 3	**September 2000** ATNN is established.
Target 4	**October 2000** ATNN develops a workplan with review and priority ranking of Task Force report recommendations.
Target 5	**November 2000** ATNN begins detailed review and analysis to implement specific recommendations as per workplan.
Target 6	**March 2002** Permanent funding from OSAB is reviewed to support on-going coordinating role of ATNN.

APPENDICES

APPENDIX A - Terms of Reference for the Substance Abuse Task Force
APPENDIX B - Substance Abuse Task Force Membership
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APPENDIX D - Niagara Addiction Agencies Inventory of Services
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APPENDIX G - Consultation – Service providers
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APPENDIX I - Niagara Addiction Treatment System Logic Model
APPENDIX J - Niagara Addiction Treatment System: Current Partnerships
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APPENDIX A

Terms of Reference For the Substance Abuse Task Force

APPENDIX A

DRAFT TERMS OF REFERENCE FOR THE SUBSTANCE ABUSE TASK FORCE

I Background

In 1996/97, the Ontario Substance Abuse Bureau commissioned restructuring studies in each of Ontario's six health planning regions. The goal was to determine how to make the best use of addiction treatment resources in each region, and how to structure services to meet clients' needs. The report, Addiction Treatment Services Restructuring in Central West Region: Final Report to the Ontario Substance Abuse Bureau was released in May 1997. Local community feedback to this report was provided through community consultations. Information collected was reported in the Niagara District Health Council's report, Addiction Treatment Services Restructuring in Central West Region: Final Report to the Substance Abuse Bureau – Niagara's Community Feedback. (1997)

In January 1999, **Setting the Course A Framework for Integrating Addiction Treatment Services in Ontario** was released by the Ontario Substance Abuse Bureau as the next step in the review of addiction treatment services in Ontario. The framework lays out the steps that can be taken to improve the quality of addiction services, coordinate services and make more effective use of addiction resources. It describes the strategies that government, district health councils, addiction agencies and others involved in the field will use over the next three years to plan a client-centred approach to addiction treatment. The goal is to provide a more coordinated, efficient system of treatment services in Niagara.

II Vision

That all people in Ontario with an addiction problem will have access to an integrated, client-focused system of evidence-based, cost effective services designed to meet their diverse needs as well as the needs of family members and others affected by someone's addiction. The system exists to meet the needs of people with addictions, who are the focus of the system. The system will continually evolve and adapt, to reflect new knowledge; changing client needs and changes in the broader health and social service system.

III Goals

- To ensure that each district of the province offers an appropriate range of addiction services and has access to specialized programs in other parts of the province.
- To ensure that clients have access to appropriate addiction services and, in particular, to ensure that more people have access to services now in short supply.
- To ensure that clients can move easily from one part of the system to another.

- To ensure that research knowledge is transferred into practice and used to shape treatment programs.
- To make the most effective use of the resources available for addiction treatment.
- To develop an integrated system of services that function efficiently and effectively.
- To encourage individual services to work as part of an integrated, client-focused system and develop a multifunctional approach to the services they provide.
- To clearly identify the roles and responsibilities of addiction agencies in the addiction system, the services they provide and the clients they serve.

IV Principles

The Framework is based on the following principles:

For Clients:

- Clients have a right to receive efficient, effective services.
- Clients and families will be actively involved in determining their own recovery and care.
- Clients will be assessed and offered the least intrusive intervention that is most likely to help them regain their health.
- Clients will receive care as close as possible to their homes.
- Clients will have access to a range of programs, philosophies and approaches, which reflect their diverse needs.

For Addiction Services:

- Addiction services in Ontario will be based on the best available knowledge and research.
- Addiction services in Ontario will be innovative.
- The addiction services in a community will offer a range of treatment approaches and give clients a choice of treatment options that best suit them and their life experiences. The relationship among programs and agencies will be based on mutual respect for different approaches and philosophies.
- Addiction services are accountable to their clients, their communities and government for the quality of the care they provide and for the efficient, effective use of their resources.
- Addiction agencies will have a clearly defined role in the addiction service system and will be accountable to the broader addiction service system for fulfilling their defined role.
- Addiction services are part of the broader health and social service system and will develop effective working partnerships with other sectors whose services could benefit their clients.

For The Addiction Service System:

- The system exists to meet the needs of people with addictions, who are clients of the system rather than clients of individual agencies.
- The system will build on the strengths of Ontario's addiction treatment services, including their knowledge base, values, experience and tradition of volunteerism.
- The system will be flexible enough to meet the needs of the large numbers of people living in large urban centres as well as the smaller numbers of people living in rural and less populated parts of the province.

- The system will develop specialized programs to meet the needs of underserved populations and to fill gaps in service.
- The system will be developed by using existing resources more effectively.
- Every effort will be made to shift funding from administration and overhead to service delivery.

V Membership

- The Steering Committee membership shall be seven members and three ex-officio members and as a minimum will include the following:
- **Community members at large**: Seven members as recommended by Mental Health Advisory and Addiction Services Mobilizing Committees (including a NDHC member, if desired).
- **Ex-officio**: Three members including: one nominated by the Niagara Addiction Services Mobilizing Committee; a representative of the Ontario Substance Abuse Bureau; and the Executive Director, Niagara District Health Council.

VI Chair

The chair of the Steering Committee shall be a member of the committee and will be elected by the committee.

VII Staff

The Steering Committee will be resourced by health planning staff from NDHC.

VIII Meetings

The Steering Committee shall meet monthly or as required.

IX Objectives

- To orient Task Force members and to finalize the Draft Work Plan
- To improve how we deliver services in Niagara.
- To improve how we monitor and evaluate services in Niagara.
- To improve how we structure, plan and organize services in Niagara.
- To prepare a discussion paper for community consultation.
- To solicit feedback on the discussion paper.
- To prepare the final report for Council's consideration.
- To forward the approved report to Ontario Substance Abuse Bureau.

X Confidentiality

Members of the Niagara Substance Abuse Task Force are subject to the same confidentiality rules as Niagara District Health Council members.

XI Conflict of Interest

Members will have a working understanding of the Conflict of Interest policy of the NDHC and are expected to deliberate impartially and act in the best interest of the Niagara Region as a whole.

XII Timeframe

The Niagara Substance Abuse Task Force is to be struck March 1999 and is expected to complete its work and report to Council by September 30, 1999 consistent with Ministry of Health timeframes.

March 1999

APPENDIX B

Substance Abuse Task Force Membership

APPENDIX B

SUBSTANCE ABUSE TASK FORCE MEMBERSHIP

NAME	*ORGANIZATION*
Mary Dobson	Coordinator, Mental Health Services St. Catharines General Hospital
Lisa Horvatek	Community Support Worker, West Niagara Mental Health Program, Region of Niagara
Philip Durrant	Coordinator, Social Services Worker Program Niagara College of Applied Arts & Technology
Susan Raymond	Health Care Coordinator, Niagara Detention Centre
Dean Sayers (Resigned Oct./99)	Program Director Assistant Healing & Wellness Coordinator, Aboriginal Alcohol & Drug Program Fort Erie Native Friendship Centre
Mariea Mc Nelis	Vice-Chair, Niagara District Health Council
EX-OFFICIO MEMBERS	
Adrienne Jugley	Chair, Addiction Services Mobilising Committee
Lisa Villeneuve	Community Program Consultant, Community Health Division, Ontario Substance Abuse Bureau
Heather Chalmers	Consultant, Centre for Addiction & Mental Health
Gary Zalot	Executive Director, Niagara District Health Council
STAFF SUPPORT	
Vicky Guertin	Health Planner, Niagara District Health Council
Penny Pomeroy	Senior Health Planner, Niagara District Health Council

September 1999

APPENDIX C

Addiction Treatment Service Definitions – Ontario Substance Abuse Bureau, Ministry of Health and Long-Term Care

APPENDIX C

ADDICTION TREATMENT SERVICE DEFINITIONS – ONTARIO SUBSTANCE ABUSE BUREAU, MINISTRY OF HEALTH AND LONG-TERM CARE

Introduction

In order to have consistent language across the addictions treatment system, the following standard definitions of service delivery have been developed. Consensus about, and use of the definitions are necessary among all stakeholders in order to report, monitor, plan, evaluate and provide service to clients.

The Substance Abuse Bureau will use the definitions for provincial rationalization and monitoring the utilization of, and resources allocated for, the services provided by the agencies they fund. Service providers and planners within local systems will be able to use these definitions at the planning stage and for the admission and discharge of clients. DART will use these definitions for agency reporting and for the provision of information to the public and professionals about the availability of treatment. DATIS will use the definitions to collect information about the utilization, cost and outcome of Ontario's addiction services.

Definition of a Treatment Service

A "service" refers to a broad category of specialized addiction treatment or support that constitutes part of the continuum of care. A treatment service is comprised of a collection of specific activities or clinical modalities (e.g., relapse prevention, psychotherapy, family therapy, pharmacotherapy, motivational interviewing, social skills training, crisis management).

The increase in the number and range of "services" under the same organizational entity (i.e., multi-functional agencies) is one of the specific goals of the provincial rationalization project. Currently, treatment "services" exist in a wide range of organizational contexts, and it is not the purpose of this report to provide definitions of these various contexts. Some services operate within a larger "program", which in turn may operate within an independent, free-standing "agency". In other instances, the treatment service may be provided within a program sponsored by a larger organization such as a public health unit or hospital. In still other instances, a treatment service provides particular activities that are grouped into specific programs (e.g., a family intervention program, a Guided Self-Change program, and a relapse prevention program).

While it is beyond the scope of this report to define the various organizational contexts in which treatment services exist, there will be a subsequent need to define common reporting units for OSAB, DART, DATIS and perhaps other information systems. This process will be initiated and monitored by the OSAB, using, for example, OSAB numbers or DART reporting numbers. Each reporting unit will provide one or more of the services defined in the next section.

Categories of Service

Entry: activities and decision-making steps, which underlie the process by which someone obtains information about and/or enters the addiction treatment system. Includes ***Inquiry Contact*** (a request for information about agency programs, the treatment system, or other issues, made by a person from the community, a staff member from another agency, or another professional); ***Intake*** (contact with a person to determine whether he or she is eligible for agency services, to register the client into the agency, and

to orient the client to services available at the agency); and ***Screening*** (a brief process that collects information in only enough detail to determine the client's immediate needs and to provide direction for next steps in the assessment/treatment process. The screening process can also provide information to clients, which assists clients in clarifying their own position regarding next steps. Screening may occur in an individual or group format.)

The various activities in **Entry Services** may occur by telephone, Internet, or face to face, and may be conducted in one session or more, in one or more locations, and individually or in a group.

Initial Assessment/Treatment Planning Services: The ***initial assessment*** is a process involving mutual investigation or exploration that provides the clinician with more detailed information for the purpose of determining specific client needs, goals, characteristics, problems and/or stage of change. Assessments vary in length according to the client's situation, and comprehensive assessments may be reserved for clients with more complicated histories and problems. This assessment forms the basis for initial ***treatment planning,*** a process of negotiation based on feedback from the assessment results, the client's strengths, prioritized problem areas, clinician judgement, client preferences and readiness for change, and the identification of potential barriers to treatment entry. This culminates in the development of a clear plan of action, including referrals as appropriate.

Case Management Services: a process which includes the designation of a primary worker whose responsibilities include the ongoing assessment of the client and his/her problems, ongoing adjustment of the treatment plan, linking to and coordination of required services, monitoring and support, developing and implementing the discharge plan, and advocating for the client. Case management services are offered regardless where the individual is in the system.

Community[1] Treatment Services: 1-2 hour sessions in group or individual format, typically once a week or less often, while the client resides elsewhere in the community. Community counselling/treatment includes brief intervention, lifestyle and personal counselling to assist the individual to develop skills to manage substance abuse/gambling and related problems, and/or maintain and enhance treatment goals. Such activities as relapse prevention, Guided Self-change, family intervention, follow-up and aftercare are included here. Care may be provided with or without medical/psychiatric treatment. Frequency and length of sessions may vary depending on client need and program format. May be offered in a variety of settings including outreach to the client's home, school, an addiction agency or other service setting. Outreach includes activities such as early intervention but not prevention, education or public relations activities.

Community Medical/Psychiatric Treatment Services: a specific non-residential service to meet the needs of individuals with concurrent disorders. This service may be offered either through a structured day/evening program or community treatment. These services are usually part of broader hospital services and employs physicians, nurses and staff specializing in the treatment of concurrent disorders.

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[1] In keeping with efforts to focus on substance abuse/gambling treatment and related services from the *client's perspective*, the terms "community" and "residential" are used throughout this document to refer to *where the client lives while accessing the service.* These terms are not intended to imply anything about the agency or service provider, such as location, sponsorship or philosophy.

Community Day/Evening Treatment Services: a structured, scheduled program of treatment activities typically provided five days or evenings per week (e.g., 3-4 hours per day) while the client resides at home or in another setting, including residential support services, to assist the individual to develop skills to manage substance abuse/gambling and related problems.

Residential Treatment Services: a structured, scheduled program of treatment and/or rehabilitation activities provided while the client resides in-house, to assist clients to develop and practise the skills to manage substance use and related problems. In addition to the scheduled program activities there is 24 hour access to support and the residential treatment milieu.

Residential Medical/Psychiatric Treatment Services: a structured, scheduled program of addictions treatment and/or rehabilitation activities provided for clients whose biomedical, emotional and/or behavioural problems are severe enough to require individualized medical/psychiatric care, while the client resides in-house. The treatment and/or rehabilitation is intended to assist the individual in stabilizing and managing his/her medical/psychiatric problems while also addressing the addiction problem per se, or to allow for referral to appropriate substance abuse/gambling treatment. In addition to the scheduled program of addictions treatment and rehabilitation activities there is 24 hour access to support and the residential treatment milieu.

Residential Support Services Level I: Housing and related recovery/support services such as lifestyle counselling, coaching for activities of daily living, community reintegration, vocational counselling and mutual aid, provided to clients who require a stable, supportive environment prior to, during, or following treatment which is accessed elsewhere.

Residential Support Services Level II: Housing/accommodation in alcohol/drug-free setting. Addiction services are not offered on-site or as part of the housing service.

Community Withdrawal Management Services: Assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. Clients may be simultaneously accessing residential support services, or they may be residing in their home, the home of a significant other or in another community setting, supervised or unsupervised. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided. Service is provided according to three levels. (See the note below describing the three levels.)

Level I **Level II** **Level III**

Residential Withdrawal Management Services: Assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. This care is provided in a Withdrawal Management (detox) Centre, or on an inpatient basis in a hospital. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided. Service is provided according to three levels. (See the note below describing the three levels.)

Level I **Level II** **Level III**

Note:

The following three levels apply to both community and residential withdrawal management services.

At all levels, clients who are not taking any medication are considered/assessed for admission.

Level I

Client symptoms can be safely monitored by staff who are not medically trained.
Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department.
Client/staff ratios do not permit high intensity symptom monitoring.
In consultation with a physician, if necessary, consider/assess individuals for admission who are taking the following types of medication:

- Medications for medical problems
- Medications for diagnosed psychiatric problems
- Pain medications only for acute injuries or recent surgery

Level II

Client symptoms can be safely monitored by staff who are not medically trained.
Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department.
Routine medical consultation and sufficient staff resources are available to consider management of the following medications/situations:

- All medications as listed in Level I
- Clients on methadone
- Clients being tapered from benzodiazepines or narcotics

Level III

Client symptoms require monitoring by medically trained staff.
Medical consultation and staff are available on a constant basis to monitor and manage the following medications/situations:

- All medications as listed in Level I
- Circumstances as listed in Level II
- Medically- assisted withdrawal

APPENDIX D

Niagara Addiction Agencies Inventory of Services

NIAGARA ADDICTION AGENCIES INVENTORY OF SERVICES

AGENCY: NADAS: SUBSTANCE ABUSE AND GAMBLING

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
A) EMBEDDED SERVICES											
1) Assessment/ Treatment Planning	• 1 session (1-11/2 hours) and 6 mos follow up. • appointments • walk-in M-F 1 to 5 p.m.	St. Catharines, Niagara Falls, Welland, Fort Erie, Grimsby/ Beamsville, Secondary Schools in Region	• Any age • Under 12 with parental consent	Substance 1023 Gambling 87 Total: 1649	Substance 529 Gambling 10			9 FTE clinical 1 Adm 2 clerical support	Ministry of Health		
2) Referral/Case Management	• 6 mos follow up	St. Catharines, Niagara Falls, Welland, Fort Erie, Grimsby/ Beamsville, Secondary Schools in Region	• Any age • Under 12 with parental consent	913 Total: 1361*	448						• results from A/T planning therefore duplicate #'s * • some may decline referral • referrals made to agency - provided services (eduction/ counselling) and external resources (addiction specific and general) • number is duplicate of assessment/ treatment *
3) Community Treatment Services - Education Counselling for Client	• 2 mos weekly or bi-weekly • 1 hr sessions • individual and conjoint • 6 months follow up	St. Catharines, Niagara Falls, Welland, Fort Erie, Grimsby/ Beamsville, Secondary Schools in Region	Referred from Assessment	Substance 787 Gambling 86 Total: 1226 *	Substance 348 Gambling 5						

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
4) Community Treatment Services - Education Counselling for significant others	• 2 mos weekly or bi-weekly • 1 hr sessions • individual and conjoint • 1 month follow up	St. Catharines, Niagara Falls, Welland, Fort Erie, Grimsby/ Beamsville, Secondary Schools in Region	• Any age • concerned/ affected by another person's substance use.	Substance 435 Gambling 32 Total: 539	Substance 71 Gambling 1						
B) OTHER PROGRAMS											
5) Adult Choices (Coed)	• 10 per group • 5 weeks • 1 hour sessions	St. Catharines	Pre-contemplation stage assessed by NADAS or screened by trained referral sources such as probation/parole	26							• group offered 3 or 4 times a year on demand.
6) Niagara Detention Centre Contemplators Group	• 10 per group • 5 weeks • 2 hour sessions	Niagara Detention Centre	male incarcerated	72 7 groups in 98/99							• runs continuously except for recesses in summer and Dec/Jan.
7) StreetWorks (Coed)	• drug users • street workers • 8 months stay on average • 30 min sessions • health teaching • harm reduction supplies • support/counselling	Mobile Outreach		48				1 counsellor 1 evening per week from 6 to 11 p.m.		Formal service agreement with AIDS Niagara	

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
8) Panic Anxiety Disorder Group (Coed)	• 10 per group • 10 weeks • 2 hour sessions	• St. Catharines (evenings 3 times a year) • Welland (afternoon 3 times a year) delivered by Region only	Co-occurring panic anxiety disorder and substance abuse screening by community mental health program.	24 in St. Cath. evening						Formal service agreement NADAS and CMHP Regional Niagara Public Health - St. Catharines location only	
9) Family Workshop	• 20 per group • 3 hour session • pre-group sign up only • once monthly last Thursday 6 to 9	St. Catharines	• any significant other concerned/ affected by another person's substance use.	43							
10) Youth Choices (Coed)	• 20 per group • precontemplators 2-60 min sessions • contemplators 4-60 min sessions • 1-2 month stay	School based program in Niagara Region	Students in pre and contemplatative stages assessed by OTEC or screened by school	85							
11) Opening Doors (Coed)	• 12 per group • 17 weeks • 60 min sessions • average 6 month stay • 5 session component for parents	Secondary schools in Grimsby, Welland and St. Catharines	High risk students for multi-domain problems identified through pre-program testing of all Grade 9 students	37						School based program delivered in partnership agreement with OTEC, Centre for Addiction and Mental Health and local high schools	
12) Downtown Family Walk-in Clinic	• single 1 hour session every Thursday from 4 to 9 p.m. • referral to community	St. Catharines	Open to general public, youth and family members concerned about substance abuse, gambling and mental health.	154 (Numbers included in Ed/ Couns. for Family Member/ significant other)						Formal service agreement between OTEC and Niagara Centre for Youth Care	

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
13) Niagara Addiction Services for Seniors		Clients residence		6						NADAS member of broad-based committee formed to integrate addictions with other established senior services	• Anticipated increase
NADAS TOTAL*				1912	611						

* Total does not include duplicates under referral/C.M. Community Treatment for Client Concern Downtown Family, Seniors.

AGENCY: NIAGARA DETOX CENTRE - DEPARTMENT OF THE HOTEL DIEU HOSPITAL

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
1) Intoxication and Withdrawal Management	• average stay 5-7 days • day stay or residential • telephone support given to off-site clients • 24 hour service • methadone clients accepted	St. Catharines	• intoxicated with alcohol/other drugs or suffering withdrawal symptoms or is in crisis because of alcohol or other drug use • must be conscious, ambulatory and not violent at admission	Males 1437 Females 664 Supportive assistance: Male 149 RP 102 125 63 pre tx 14 post tx 46 RD		Male - 22 beds Female - 14 beds				• Host peer support meeting 5 times a week with AA and ALNON. • Day treatment program for men through resource service agreement with ADTC.	• a regional program with gender specific programs • transportation can be provided • full medical backup through hospital emerg.
2) Discharge Planning	• inpatient clients • referrals	St. Catharines									

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
3) Pre-Treatment Stabilization	• drop-in support 24 hours on-site or telephone	St. Catharines				Male - 3 beds Female - 2 beds (included in withdrawal bed count)					• clients who have a confirmed treatment date and have special circumstances are eligible for extended stay. Average length of stay 3 weeks. Post treatment stay for extraordinary reasons up to 48 hours.

AGENCY: BRANSCOMBE HOUSE (ADMINISTERED BY NIAGARA DETOX CENTRE)

Residential Support Services Level II for women

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
Branscombe House	• peer support transition house for women in recovery • single and parent/child accommodation available	St. Catharines	Women in recovery			6 beds					

AGENCY: ARID GROUP HOMES (NIAGARA)

Residential Support Services Level I

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
1) Recovery Home	• Men's recovery half way house • Non-medical supportive environment • Mid-term facility with average length of stay of 3 to 6 months	Thorold and Fort Erie	• Males with alcohol or drug addiction • Age 21 and over	59	Included	14 beds (increase to 16 in June '99)	80%	2.5	Ministry of Health 27% (37,619)		• own their own property • 12 step program • can be on social assistance • provide one-on-one counselling • referrals from Detox, EAP, self and medical facilities • exclude those on Federal parole and those needing specialized psychiatric medical care

AGENCY: WAYSIDE HOUSE NIAGARA

Residential Support Services Level I

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
1) Intake/Screen 2) Recovery Home	• Men's recovery half way house • supportive programming • average length of stay 3 to 4 mos	St. Catherines (50 Queenston Street)	• men who can live in a supportive environment • 17 years +	92	16 Total = 108	40 beds (20 OSAB funded)	85%	8.5	86% Ministry of Health $402,263 minus rental clawback ($3,000 98-99)	Informal arrangement with ADTC for day treatment intake one morning per week.	• house owned by Wayside • follows 12 step program • majority of referrals from Detox • can be on welfare assistance • offer in-house group programs with focus on life skills and one-on-one counselling • average # of residents is 30

AGENCY: ALCOHOL & DRUG TREATMENT CENTRE (NIAGARA)

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
1) Entry Services	• intake/screening • initial assessment • treatment planning	St. Catharines (15 Church St.)	• individual addicted to alcohol and/or drugs • 18 years +					7.7	Ministry of Health (100%)	• management service agreement with Hotel Dieu • Informal clinical intake arrangement with Wayside	Totals: • Admissions for analysis = 909 • Number carryover = 195 • New admissions = 714 • First admissions = 575 • Re-admissions = 334 • District individual = 730
2) Case Management	• available to all ADTC clients to coordinate treatment plans both internally and externally • 1 to 6 individual sessions • ALOS 4 sessions		• individual addicted to alcohol and/or drugs • 18 years + • willing to abstain for duration of program	600	included						
3) Day Treatment Program	• 4 week intensive non-residential program • 6 hours per day • ALOS 20 days • includes cognitive educational and experiential components	St. Catharines (15 Church St.)	• individual addicted to alcohol and/or drugs • 18 years + • willing to abstain for duration of program	150	included						

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
4) Early Treatment	• 12-16 per group • 2-4 weeks of 1.5 hours/wk • ALOS 3 sessions • weekly educational program and supportive group sessions for clients in early recovery • prepares clients for intensive day treatment		• individual addicted to alcohol and/or drugs • 18 years + • willing to abstain for duration of program	286	included						
5) Relapse Prevention	• individual and group • 8-12 per • 6 hours over 6 weeks • ALOS 4 sessions		• individual addicted to alcohol and/or drugs • 18 years + • willing to abstain for duration of program • previous treatment experience preferred	73	included						
6) Coed Aftercare	• 15 per group • 3 support groups offered weekly • 3-12 mos; 1.5 hrs/wk • ALOS 3 mos		• 18 years of age, treatment completed	173	included						
7) Women's Aftercare	• 15 per group • 3-12 mos; 1.5 hrs/wk • ALOS 4 months		• female 18 years of age or older • treatment completed	45	included						• approx. 50 per year
8) Gender specific Anger Management	• individual and group • 15 hours over 7 wks • ALOS 4 sessions		• 18 years of age, treatment completed • anger issues related to recovery process	96	included						• approx. 100 per year

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
9) Family Program	• 8-12 per group • individual and group • 4-6 sessions (1 hr individual 2 hr group) • ALOS 5 sessions		• 16 yrs of age and older • ongoing significant relationship with someone who is a substance abuser	138	included						
10) Family Aftercare/ Continuing Care	• 8-12 per group • group and individual • 3-12 mos • ALOS 4 mos		• 16 yrs of age and older • ongoing significant relationship with someone who is a substance abuser	33							
11) Couples Program	• individual and workshops • maximum 6 sessions • ALOS 4 sessions		• 18 years of age and older • one or both in recovery • previous treatment experience	14							
12) Concurrent Disorder	• brief counselling for clients with mental health concerns and substance abuse issues • 6 individual sessions • ALOS 5 sessions			23		30 cases					

AGENCY: WARM - WOMEN'S ADDICTION RECOVERY MEDIATION

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
A) PERSONAL DEVELOPMENT/LIFE SKILLS GROUP PROGRAM											
1) Loss Management	• to educate women on cycle of grief pertaining to personal losses in life • 8 weeks/2 hrs per week	Fort Erie and Welland	Female over 16 years					Total - 3 full time - 2 casual	- Fundraising - United Way		• Programs are not continuous. On need basis.
2) Anger Management	• 6 weeks/2 hr per week • 10 per group										
3) Communication Skills	• 6 weeks/2 hr per week										
4) Adult/Child	• family issues • 6 weeks/2 hr per week										
5) Relapse Prevention	• recovery maintenance • 6 weeks/2 hr per week										
6) Smoking Cessation	• 12 wks/2 hrs per wk • 6 wks/ 2 hrs twice a wk										
7) Self-esteem enhancement	• 4 weeks open group/ 2 hrs per wk										
B) INDIVIDUAL CARE											
1) Individual counselling	• Intake, assessment, individual care plan, referral to other appropriate services, individual counselling • Evaluation after 10 individual sessions.	Fort Erie, Welland, Port Colborne	• Over 16 years, female with substance abuse problem • Will provide services to males on an as needed basis	1998 673 contacts Individuals - Ft Erie 222 - Pt.Colb 13 - Welland 18						• Informal service agreement with NADAS for complete assessments • Clients in need of detox referred to Detox St. Catharines	

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
C) ADDICTIONS PROGRAMS											
1) Recovery Group	• 10 women per session	Fort Erie	• over 16 years, female or a family member with addiction issues	24 individuals 159 contacts							
2) Outreach Services	• 1 hr/once or twice a wk • ALS 4-6 months	Fort Erie, Crystal Beach, Port Colborne, Welland	• child care and/or transportation issues	75 individuals 128 rides							
3) Women's Retreat	• 19-33 individual • Twice per year • Weekend	Mount Carmel, Niagara Falls	• over 16 years of age, female with substance abuse problem and family members	53							• 12 step philosophy
4) Community Wellness	• 60 individuals • 3 times per year • life style wellness • address issues that may affect relapse	Fort Erie Library Port Colborne	• open	37							
			Total Individuals Served: Fort Erie 284; Niagara South 42; Other 17.								

AGENCY: FORT ERIE NATIVE FRIENDSHIP CENTRE

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
1) Sharing/Healing Circles	• 12 per group • continuous	Fort Erie	• Open						MOH/Aboriginal Programing		
2) Traditional nature drum/singing	• 40 • continuous • healthy life style activities	Fort Erie	• Open								
3) Prayer Circle	• monthly • continuous	Fort Erie	• Open								
4) Self Administered Tx Program Outpatient	• Referral, case managment • 40 • continuous	Fort Erie or outreach	• Open								
5) Education Prevention Activities										• Education Program for inmates at Niagara Detention Centre	
Total clients per year = 120											

AGENCY: NEW PORT CENTRE

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
A) COMMUNITY TREATMENT SERVICES - OUTPATIENT											
1) Individual and Group Counselling Case Management	• ALS 3-4 months	Port Colborne Off site in Niagara Falls, Welland, St. Catharines (1 day per week)	• over 16 years problem with substance abuse	671	333 **Total = 922**	Outpatient/ Case Management calculated at 60 cases per counsellor		27.52 FTE's 1 FTE Exec Dir. 1 Intake 1 Admin Support 1 Prog. Coord. 3 team leaders 20.52 direct clinical	MOH 100%	Offsite space provided by WCGH, GNGH, CARSA	Serves Region of Niagara
2) Body Image Group; Eating Disorder Support Group; Turning Points Program; Eating Disorder Group	• 12 per group • 6 to 8 weeks • support group is open • ALS 3-6 months • The programs run throughout the year	Port Colborne	• over 16 years, eating disorder problem	75 support group and body image		100 cases per year				Partnerships with Port Colborne General Hospital and Dr. Wilkes	Dr. Wilkes is the specialist for this program. Must be in Port Colborne.
3) Harm Reduction/ Methodone Clinic Support (private Clinic)		Port Colborne	• over 16 years, opiate dependent per DSMIV, referral by physician					Inpatient counsellor from Newport will be working 15 hours per week providing administrative support and counselling services as required for admission to clinic		Partnership with PCGH	• **To start June 30, 1999.** • **This will reduce New Port Staffing complement.**

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
4) Choices Program	• 8-10 per group • 6 week program • ALS - 6 weeks • One morning per week as needed	Thorold	• incarcerated • over 16 years, problem with substance abuse, precontem-plation stage per transtheoretua l model of change.	74						Partnership with Niagara Detention Centre	
5) Community Walk-in Clinic	• Single session • Focus primarily on adolescents and families. Not only substance focus	Port Colborne	• over 16 years	110						Partnership with Niagara Centre for Youth Care	
6) Support Groups (aftercare program for clients from in patient)	• ALS 2-4 months • Available in generic formats and for women (CARSA) and cocaine users • on-going	Port Colborne Niagara Falls St. Catharines	• over 16 years, problem with substance abuse	84		60		1 staff Run by volunteers			Held onsite at GNGH, CARSA, Wayside House and New Port.
7) Recovery Enhancement (Relapse Prevention)	• 15 clients per session • 8 weeks • structured program	St. Catharines Port Colborne								Developed in partnership with ADTC	**Cancelled due to insufficient demand.**
8) Outreach Services	• Workers will meet with clients in various venues across Niagara Region • ALS 2-4 months	Region of Niagara and Dunnville area	• over 16 years of age, substance abuse, mobility problems	8		5-10 clients at a given time					Not high need service area but it is available.

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
9) Services to Seniors		Niagara Region	• senior citizens with substance abuse								**Program in development stage. Committee Structure**
B) COMMUNITY MEDICAL/PSYCHIATRIC TREATMENT SERVICES - OUTPATIENT											
1) Services to individual with concurrent diagnosis	• 1 counsellor, 1 day per week at GNGH and WCGH • Assist hospital clients with substance abuse issues	Welland, Niagara Falls, Port Colborne	• over 16 years, problems with substance abuse and mental health	148		60 cases per year				Partnership with WCGH and GNGH	Offered off site in hospital setting at WCGH and GNGH.
2) Impact Program	• Outreach service coordinated by SCGH, New Port • Coordinate service on-site at PCGH and WCGH										
C) COMMUNITY DAY/EVENING TREATMENT SERVICE											
1) Coed and Womens Residential Services	• structured day/evening treatment • 17 ½ days • full day treatment	Port Colborne	• over 16 years problem with substance abuse and cannot access ADTC (Niagara)	12 individuals (Added to residential Program)							

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
D) RESIDENTIAL TREATMENT SERVICES											
1) Coed Residential Services	• 18 day program • 25 clients per • Program includes psycho-educational and awareness enhancing modules • 9 sessions per year	Port Colborne	• over 16 years, problem with substance abuse	222 Full capacity Waiting list of 2 months		25 beds					• Residential Withdrawal Management Services Level II (assistance with withdrawal from substances as component of residential treatment) • usual procedure is to refer to Detox • clients accepted must be medically and behaviourally stable • Province of Ontario 62% outside Niagara • Residential treatment services must have medical staff and hospital services for most clients as must residential clients are very ill. • Clients tend to have multi-substance abuse issues and medical issues.
2) Cocaine Specific coed Residential Services	• 25 clients per session • 17 ½ days • Emphasis placed on cocaine use • 8 sessions per year	Port Colborne	• over 16 years, problem with cocaine abuse/use	158		25 clients					
3) Women's Residential Services	• 10 clients per program rotation • 17 ½ days • Emphasis on issues specific to women • 17 sessions per year	Port Colborne	• women over 16 years with substance abuse problems	158 Waiting list approx. 1 month		10 beds per rotation					• 10 children accommodated.

	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
4) Recovery Enhancement	• focuses on relapse prevention for people who have had previous treatment • 25 clients per rotation • 5 day program • offered approximately 3 or 4 time per year based on referrals	Port Colborne	• over 16 years some recovery success.	45		595 clients					Total residential clients = 584 Capacity 595 clients
5) Weekend Relationship Enhancement for Couples in Recovery	• focus on relapse prevention, communication and other relationship issues • 15 couples • 3 day weekend	Port Colborne		32		Program runs 3 or 4 times a year, as needed					Appears this is a growth area.

AGENCY: THE LABYRINTH GROUP

Program/Service Name	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
Group	• Self-help peer support for people with both mental health and substance abuse problems	St. Catharines, Welland	• Individuals with mental health and substance abuse problems	0	7	121		St.Cath. has 3 facilitators Welland has 2 facilitators	MOH Trillium		• Harm reduction
	• Open rap forum with occasional guest speakers.										

AGENCY: GAMBLERS ANONYMOUS

Program/Service Name	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
Self-Help Support Group	• 4 groups currently operating in Niagara area • weekly meetings • range 12 to 25 in attendance • individual sponsorship can be provided	Niagara Falls, New York; St. Catharines; Hamilton, Niagara Falls, Fort Erie	Self referral						Self supporting		• 12 step program

AGENCY: AIDS NIAGARA

Program/Service Name	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
Support Service Program	• Clients and then families are provided with on-going support during periods of alcohol/drug use and sobriety to promote wellness and recovery • Monday to Friday 9-5 and on call as needed • Advocate for personal and medical needs.	St. Catharines and mobile service provided across the region.	Servo + status confirmed	• current # 85 HIV clients • 30-35% have addiction problems				1 FTE (2 individuals)	Ministry of Health; Welfare Canada; United Way; Fundraising; Regional Public Health		Harm redirection, life enhancement model

Program/Service Name	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
Supportive Housing Program	• Provide health related and/or practical services to people living with HIV or AIDS who need assistance and wish to remain in a home-like environment	St. Catharines	• Servo + confirmed, Canadian citizen, demonstrated need, 18 or older • Addiction issues exist	9		9 units with waiting list		4 FTE			Harm redirection, life enhancement model
Street Works Needle Exchange Program	• Provide anonymous pratical support and education to drug users or anyone at risk in the Niagara Region to prevent the spreat of HIV/Hepatitis • Monday to Friday in office and mobile in Region - Monday, Wed, Thurs., Friday 6 to 11 p.m.	St. Catharines and mobile unit serves Niagara region	• at risk of infection	1200 contacts				1.75 FTE		• NADAS one staff on Thurs. p.m. to assist clients with addiction needs regarding recovery/ assessment. • Housing Help Centre for housing needs • Pt. Colborne pharmacy site • Safe Beds Program, St. Catharines	Harm redirection, life enhancement model
Community Outreach and Prevention	• Develop supportive environment and services for people at risk /or living with HIV • Monday to Friday and as needed	St. Catharines and Niagara Region	At risk or living with HIV	Fluctuates with demand				1 FTE			Harm redirection, life enhancement model

AGENCY: ALCOHOLICS ANONYMOUS

Program/Service Name	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
A.A.	• Fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.	Region of Niagara including St. Catharines, Beamsville, Grimsby, Welland, Pt.Colborne, Dunnville, Niagara Falls, Fenwick, Crystal Beach and Fort Erie	Desire to stop drinking.								Twelve step program.

AGENCY: DR. GEORGE DAVIDSON

Program/Service Name	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
Methodone Clinic	• Provide methadone treatment to opiate dependent clients.	St. Catharines	Self referral but must have a family physician and must want to be abstenant from opiates.			100 individuals	100%	2 FTE	OHIP		• Private practice. • Linked with addiction network. • Addresses other addiction issues.

AGENCY: PORT COLBORNE GENERAL HOSPITAL

Program/Service Name	Description	Location	Admission Criteria	New Individuals Admitted (98-99)	Carryover (98-99)	Capacity	Occupancy Rate	FTE's	Funding	Service Agreements	Approach and Comments
Methadone Clinic Dr. C. Kuhn Dr. Debbie Wilkes-Whitehall	• Opiate dependent treatment program. Will address other substance abuse issues.	Port Colborne General Hospital - Hours M-F 8:00 a.m. to 10:00 a.m.	• Individuals residing in Niagara or out of area who are opiate dependent. • All ages. • Must have family physician and valid OHIP card. • Must complete assessment process. • Must receive outpatient addiction counselling once a week while in clinic.			25 maximum (no wait list)		• Part-time social worker • 2 part-time physicians		New Port 3 hours counselling per day.	Are prepared to broader services t patients with alcohol and other substance abuse addictions.

APPENDIX E

Consultation - Focus Groups Summary Report

APPENDIX E
CONSULTATION - FOCUS GROUPS SUMMARY REPORT

AGENCY/PROGRAM SPECIFIC	SIMILAR COMMENTS FOR TWO OR MORE AGENCIES	OTHER COMMENTS
STRENGTHS		
- appointments were timely - received lots of information - cognitive approach appreciated - options and program choices - nice building - capable of identifying concurrent needs - well promoted service - especially for women - private counselling - confidential service - will provide counselling in my home if child care an issue - does not break off contact - has taught me what to do if relapse occurs - looks at overall lifestyle issues - build self esteem - someone always there if you're upset - flexible program - go at your own pace - clients function as a community - very accessible to local residents - services are close to home and family - good staff development - quick response time from initial contact to being seen and then admitted - encouraged to work on our strengths - will help you find housing, if necessary - follow up on clients to see how they are doing - program keeps me from buying dope on the streets - gradual withdrawal customized to patients needs - would never have made contact with an agency in the standard manner - benefit from harm reduction information - good that someone is monitoring my health	- caring staff - knowledgeable staff - treated with respect - made to feel comfortable - responsive to client needs - staff with personal addictions experience - will see you right away - will counsel you on phone - good communication among addictions agencies - help in accessing other addictions services - counselling for families is helpful - good food - clients can make own choices and decisions - good structure and daily routine - can access AA while using service	- have substance abuse counsellor at workplace - detention centre resources plentiful

AGENCY/PROGRAM SPECIFIC	SIMILAR COMMENTS FOR TWO OR MORE AGENCIES	OTHER COMMENT
BARRIERS/WEAKNESSES		
- services are not well promoted - more information about alcohol/drugs needed in french school system - more alcohol/drug education needed in all school curriculums - need more physicians who understand addiction and mental health issues - need more education for health care professional about addiction - general public awareness of addictions needs to be increased to reduce stigma - need halfway houses for women - need more transitional houseing - growing need for gambling addiction services - insufficient funding for services - clients should not have to bring their own coffee - need staff continuity - provide more consistency in staff messages - vacation schedules should allow for staff continuity - program sometimes lacking in structure - need active participation, not just lectures and handouts - need more information while receiving services - no follow-up when program completed - need full medical workup - parenting classes should be offered - some need help with reading materials - AA not available	- need more flexible hours - evening and weekend hours needed - waiting lists are too long - lose people who are waiting for services - services are understaffed - poor access to services because of transportation issues - not enough help for partners/families - day treatment and residential programs too short - need more individualized care - need coordination or integration between mental health and addiction systems - need more flexibility in agency policies	- need to access treatment in jail - need medical detox - some doctors over prescribe medication - need family doctor's referral to methadone program or psychiatrist which is impossible if you don't have a family doctor

CLIENT FOCUS GROUPS - SUMMARY REPORT - SYSTEM

REPEATED CONCERNS	ADDITIONAL PROGRAM SUGGESTIONS	OTHER COMMENTS
- need for increased health promotion/education/social marketing - outreach/screening/aftercare shortfalls - need outreach services directed to francophones - need for increased residential support - particularly for women - transportation issues and the need for services throughout the region - need more flexible treatment hours and longer time in treatment programs - need for improved linkages with other service systems (e.g. physicians and mental health workers) - need more funding for addictions services	- need a 24 hour drop-in centre - need medical detox - need harm reduction programs - need more options for spiritual advice and support - need self-help groups that are not 12-step based - need enhanced opportunities for socializing in safe places	- leave system as it is - there are no significant overlaps in the system - don't structure the system to death - tobacco addiction is a common issue - more money needed for social assistance - stop police corruption around cocaine

APPENDIX F

Consultation – Community Stakeholders

- *List of Participants*
- *Summary Report*
- *Evaluation Report*

APPENDIX F

CONSULTATION - COMMUNITY STAKEHOLDERS
LIST OF PARTICIPANTS
Friday, September 10 - 8:45 - 12:00 -- Niagara Suites

Name	Position	Agency/Dept
Tessie Ambrosia	Staff Nurse	Psychiatry, St. Catharines General Hospital
Cindee Barrow	Clinical Supervisor	Mental Health Services, Welland County General Hospital
Rick Borgatti		Mental Health Services, Welland County General Hospital
Chris Boyer	Community Representative	New Port Centre
Sherri Boyer	Facilitator	Labyrinth
Connie Bucknall	Executive Director	Community Care - Beamsville
Jackie Carney	Community Representative	
Derek Christensen	Registered Nurse	Impact Niagara, SCGH
Kyla Cormier	Consumer Employment Developer	CMHA - St. Cath & District
Bill Craine	Program Advisory Committee Member	Addiction Services Hotel Dieu Hospital
Don Crocock	CEAP, Union assistance Program Coordinator	USWA Local 5788
Bill D.	Community Representative	New Port Centre
Larry Dahmer	Staff	New Port Centre
Mary Lou Davidson	Officer	Niagara Regional Police
Deanna D'Elia	Coordinator	YMCA - St. Catharines Employment Services
Tammy Falovo	Support Services	Ontario Brain Injury Asssoc.
Kent Gabel	Staff	New Port Centre
Margaret Gifford	Community Corrections	Niagara Detention centre

Name	Position	Agency/Dept
Margaret Griffiths	Program Coordinator	Women's Place
Shelley Hagan	Coordinator	YMCA - St. Catharines Employment Services
Frank Healey	Social Worker	NCDC
Jean Irish	Coordinator	Niagara Evaluation Team
Mike Jenkins	Community Representative	New Port Centre
Gerald K.	Community Representative	New Port Centre
Milica Kovacevich	Executive Director	YWCA
Hugh MacDonald	Machine Operator	Dana Corporation
Finola Malone	Case Manager	Ontario Works Division Field Welfare Department
Tricia Malstrom	Team Leaders	Ontario March of Dimes
Mandy Mason		Brighter Futures
Willy Mason	Independent Lifestyles Counsellor	Canal View Homes
Jackie Mazur		Alcoholics Anonymous
Gary Minshull	Inspector	Dana Corporation
Jane Moon	Counsellor	Design for a New Tomorrow
Dr. David Nicholson	Physician	
Heather Patterson		Fort Erie Native Centre
Blair Phillips	Chemical Dependency Counsellor	
Debi Poppe	Director of Supportive Housing	YWCA St, Catharines
Dianne Radunsky	Support Services	Ontario Brain Injury Assoc.
Rob		Ontario March of Dimes
Bill Roberts	Co-Chair, PI/CPC	Alcoholics Anonymous
Heide Schonhaar	Client Services Coordinator	Community Care
Joe Smith	EAP	Local 150 CUPE

Name	Position	Agency/Dept
Cheryl Stock	Case Manager	Ontario Works
Al T.	Community Representative	New Port Centre
Nicole Taylor	Youth Program Counsellor	Niagara South Parent Support
Joy Taylor		Alcoholics Anonymous
Terri VanGemeren	Social Worker	Niagara Detention Centre
Christine Weasner		Niagara South Parent Support
Mary Ellen White	Geriatric Intensive & MH Outreach Case Manager, MH Program	Geriatric MH Outreach
Nancy Wilson	Community Program Nurse	Seniors Community Program
Sharon Winning		Gateway
Laurie Wolfson		Mental Health Program, St. Catharines General Hospital

APPENDIX F

CONSULTATION - COMMUNITY STAKEHOLDERS SUMMARY REPORT

(Indented responses appear in more than one question.)

1. What are the strengths of the existing Niagara addiction system?

Access:
- Easy (no long waiting lists), co-ordinated with multiple levels of open referral.
- 24 hour crises care at detox
- Links between workplace sites and service providers – EAP's
- Outreach services attempt to provide service across the region
- Opportunity to return to programs
- Flexible referral criteria

Continuum of services:
- Variety of services and choice. More direct focused with a variety of options.
- No cost.
- Diverse approaches beginning across service providers. Family perspective in treatment.
- Now have increased methadone services.
- And more self-help services.
- Increased partnering is taking place between agencies.
- Services are integrated, continuity of individual treatment.
- Holistic approach.
- Follow-up after residential.
- Preventative programs are improving; increased outreach programs.

Staff:
- Experienced, knowledgeable and committed.
- Recovered.
- Good staff co-operation.

Integrated system:
- Liaison with hospitals – New Port.
- ASMC brings services together
- Interagency network.
- Agencies partner to remove gaps. New Port, Detox, Wayside and NADAS for example.
- Agencies re-evaluate programs – New Port.

2. What are the gaps/challenges in the current addiction system and what barriers do individuals and referring agencies face in accessing addiction services

Access:

- Need a more streamlined transition from correction to community services.
- Inappropriate referrals to jails with no follow-up.
    - Need one point of entry. Centralised access to information. People tend to shop around/multiple agencies involved.
- Duplication of referral sources.
    - Problem with transportation system in Niagara. Only one detox in Niagara; difficulty with transportation.
    - Problem with location of services.
    - Lack of resources and lack of support services and financial resources limit access.
    - Child care issues for women.
    - Clients having to come off meds in order to receive treatment.
    - Waiting lists – methadone clinic in St. Catharines.
    - Waiting time between Detox and treatment program.

Lack of services/ Continuum of Services:

- Limited after care services in remote areas.
- Not enough emphasis on concurrent issues. Services for homeless with concurrent disorders.
- Nicotine addictions.
- Methadone clinics.
- Youth.
- Seniors.
- Harm reduction model – focus on RPP issues only.
- Services to low threshold clients.
- Mandated clients.
- Recovery home for women. Facilities for women.
- Inability to treat ABI participants.

- Need variable stays. Reduction in number of days for residential programs. There are no longer-term treatment programs.
- Ensure drug free environment in treatment centres.
- Residential programs – lack of time spent on individuals personal needs.
- Mixing mandated clients and voluntary in same program; they have different goals.
- Lack of supportive housing.
- Only one in-patient program. Need expansion of services.
- Family services.

Lack of information:

- Information for service providers, consumers, physicians and schools. More outreach.
- Medical involvement with detox (form 1).
    - Lack of GP's. Lack of physician accountability re prescriptions.

- Education to persons with disabilities, e.g., transition from institution to home, their special needs.
- Centralised access to information

System integration:

- Need evaluation tools to monitor effectiveness of treatment.
- One point of access.
- Some lack of co-ordination between services.
- Lack of information sharing between providers and clients.
- Better co-ordinated services between addiction and mental health services. Communications break down between drug and psychiatric treatment providers. Need program to promote interaction between drug and mental health treatment.

- Broader involvement of providers on committees that are in decision-making loop.
  - Need more communication between service providers.
  - Need increased collaboration and co-operation between agencies (due to funding competition).
- Need networking, fact to face case management.
- No bias; should have different approaches for different needs; available from same provider.

Resources:

- Need for more support workers.
- Lack of resources and lack of support services and financial resources limit access.

3. Are there groups of individuals in our community that are not able to access the addiction services they need? If so, who are they and what services are required to meet their needs?

Target Group	Recommendations for improvement
Youth	Ages 12 to 15. Increase youth residential. Lack of funding for education and treatment of school age children. In need of longer treatment.
Women	Require a recovery/transition home with counselling for issues – pre and post treatment. Is there a need to expand opportunities for women or to expand existing women's groups? In need of longer treatment.
People with HIV/AIDS	In need of longer treatment.
Francophones	
Homeless individuals	Referral system for homeless.
People with disabilities	Handicap accessible services. In need of longer treatment.
Families	Services to families for support.
Older adults	Prescription drugs issue. Services to withdraw from addiction. Have different treatment issues. In need of longer treatment.

Target Group	Recommendations for improvement
Individuals with concurrent disorders	Need access and treatment. Need longer treatment.
Aboriginal people	
Ethnocultural communities	Cultural diverse groups. Treatment available only in English. Special smaller groups with links to community resources.
Gays, lesbians, bisexuals	
Problem gamblers	Gambling addictions are ignored.
Individuals in the corrections system.	

Other:

- Homeless, low income, those that lack transportation and childcare.
- Fear of retribution.
  - ABI and mental.
  - Disabled
- Is there a need for a residential adolescent program?
- For special needs participants – if programs do not meet their needs in Niagara, are there services available to them outside the Region?
  - Do mandated and voluntary clients need separate programs?
  - Multiple disorder addictions, so called hard to treat have burned bridges.
  - Psychiatric professional association with addictions field
  - Individuals in isolated areas; women, homeless, concurrent.
- Is there a service for dually diagnosed?
  - Network with existing committees.
- An organisation like COPA.
- Eating disorders.
  - Tobacco smokers

4. **Do you have the necessary information to identify individuals at risk? Do you have sufficient information about the addiction system in Niagara to make appropriate referrals? If not, what information do you need?**

   - Workshops, seminars to service workers, referring agencies. Especially in concurrent disorders. Include physicians.
   - More community outreach, public relation programs community presentations. Public awareness/training. Advertise program changes in the community.
   - Establish links with Information Niagara, local community news, existing committees, community centres, home for aged. Use Information Niagara.
   - Positive relations between hospitals and addictions agencies.

- Resource package. Detailed information from agencies. Easier access to this information.
- Web site.

- FAS/FAE
- Proper assessment tools. Generalised screening tool.
  - 1-800 number.
  - Need for improved communication with referring agency and addiction service provider.
  - Improved case management within addiction area.

5. Do adequate linkages exist among the various addiction services in Niagara? Do adequate linkages exist between the addiction service system and other Niagara community agencies?

Linkages among addiction services:

- Some agencies work in isolation – political, funding issues. Service providers need to emphasise after-care services.

- Have consent to release form for use within system.
  - Need better communication between agencies to best match clients to agencies. More collaboration.
  - Need more current information and contacts.
  - More co-operation.
- Less prejudice when a client moves to another agency.
- More compassion.
- Agencies are more politically and statistically driven rather than client oriented.
  - Adequate for now, but they could be improved. Need to co-operate and communicate to best service client. Better assessment and communication, standard assessment.
  - Need to eliminate ownership and continue/start to co-operate.

Linkages with other community agencies:

- Linkages with agencies that serve special populations are lacking.
- Communication with medical community.
- More education on addiction services.
- More linkages with mental health system.

6. What can be done to enhance the addiction system in Niagara community?

Education:

- Information on available services for service providers and general public.
- Prevention programs.
- Training for physicians.
- Networking.
- More expertise in concurrent disorders.
- Better ways of sharing information, training opportunities.

- Training on identification for non-addiction agencies.
- Education on methadone clinic.
- In-servicing for seniors and smoking cessation issues, harm reduction, hard to serve and youth.
- More positive PR.

Planning:

- More communication.
- Increased communication for funding.
- Following evidence-based practices.
- Monitor client success.
- Consumer involvement.
- Build upon existing system.

System:

- Single structure to co-ordinate /manage system. (A more seamless treatment system).
- Cross treatment between agencies, i.e. ABI, and other special populations.
- Cross discipline treatment teams to manage/address needs.
- Single point of entry. Centralised access.
- Standardised assessment tool to be used for people at risk.
- Agencies/services need to be more mobile. Volunteer transportation program.
- Less of a division between medical, addiction and mental health services.
- Regional case management. Increase/enhance strengthen case management and co-operation within agencies and EAP and services (women's rec. home, seniors services, youth etc.).
- Protocol – assessment mobility and advertise to community.

Services/programs:

- Transition home for women.
- More services across Niagara.
- Pre-treatment supports.
- After hour care.
- Methadone clinics with adequate funding.
- Day treatment options with transportation.
- Specialised treatment options.
- Specialised units for ABI, MH/Addictions.
- Drug screening within treatment programs.
- Shorten waiting lists. Waiting lists too long.
- Better approaches for hard-to-serve.
- Client/service provider/referral co-operation and communication.

APPENDIX F

CONSULTATION - COMMUNITY STAKEHOLDERS EVALUATION REPORT

Total participants = 50 Total evaluations completed = 24

1. ***Overall how would you rate this consultation***?

   A winner = 10 Met it's objectives = 12 Not sure = 2

2. ***What I found helpful was:***

- Networking; for a not-for-profit. Very informative, hospital representatives explained process for referral.
- Collaboration among various agencies/representatives from diverse disciplines.
- The diversity of the people participating made this very insightful. The different representatives gave me direct knowledged of the depth of the lack of shared information between different groups. Just meeting the different people from different agencies.
- When we discussed things we sometimes overlooked something that someone else had used. Very comprehensive.
- Sharing of ideas from different groups; providers, consumers, etc.
- Having lots of time to get to know my group and discuss issues. The structure provided for discussion.
- Information available, new ideas.
- Input from others especially direct clients; collaborative efforts; good opportunity for input; information gathering.
- Format; length of discussion; group facilitator.
- The networking available.
- Working with persons from varied backgrounds/professions.
- Networking; sharing ideas/information.
- Adequately addressed the gaps in the system, however, didn't answer the question of so what, where do we go from here.
- Sharing of information and ideas between broad spectrum of services.
- The mental health and addiction's are starting to work together.
- Opportunity to learn from/network with others.
- The ability to see several different aspects of addictions and great way to network. Bravo.
- Finding how we can best serve Niagara clients. Meeting with people of other agencies to see how best we can serve them.
- Meeting with others to find out there feedback on he abuse in general.
- The information given and presented.

- Meeting many people from different agencies.
- Various information from different sources.
- A great chance to share concerns. The mix of agencies allowed excellent interaction as well as information sharing
- The education I received will benefit my agency and consumers.

3. What I found less helpful was:

- People in the group had to leave. Reporting is always long, maybe we could have each group present only 1 question. You have the information on chart and then group could add other comments.
- Time constraints
- Reporting information
- Discussion at end re: question too long or not interactive enough.
- Some repetitiveness when taking up responses.
- Too short time period.
- Groups giving out information not everybody could be heard
- Variety of service providers that were present and consumers
- Not enough perspective and involvement from general public - not advertised/promoted sufficiently.
- Not enough hand outs
- More time would have been great.

4. Other comments/suggestions:

- I will probably arrange for an in service for my staff and volunteers in order for our organization to refer appropriately.
- The session should be a full day session. There is a lot more input and discussion that could happen.
- Program was well planned and implemented. Let's hope the messages we gave result in changes and more cooperation from Ministry.
- Have more of these discussions.
- Good morning, I like having half day forums
- Continuing consultation groups; process to implement suggestions is quick and effective.
- "Setting the Course.." report should have been available for reading prior to workshop. Would like to have seen a lot more information given on the framework.
- Would be nice to see listing of services available and how to access them in pamphlet form in every physicians office, major industry bulletin boards and schools.
- Overall excellent in providing forums to share ideas to expand, improve and contribute towards improving services and centres and providers of drug addiction services within the Niagara region.
- All groups seemed to have the same thoughts and feelings on the topics and questions, hopefully it won't be a wasted effort.

- Build on this event.
- Excellent, need more info. sessions.
- The process of gathering info, taking it to a committee, asking for report and feedback, gathering that info and then submitting a final report can be too long a process.
- Phone numbers of the other organizations so we can contact the people we sat with. Then they can tell us what to do or who to contact.
- All good.
- I feel we need more of these formats to better serve the community on a whole.
- Less time repeating information
- Could NDHC assist in better liaison methods and information sharing (e.g., forum around what the services do, who they serve, criteria, etc.)

APPENDIX G

Consultation – Service Providers

- *List of Participants*
- *Summary Report*
- *Evaluation Report*

APPENDIX G

CONSULTATION - SERVICE PROVIDERS
LIST OF PARTICIPANTS
Friday, September 10 - 12:45 - 4:30 -- Niagara Suites

Name	Position	Organization
Bill Alderman	Board Member	Alcohol & Drug Treatment Centre (Niagara)
Chris Baldissera	Team Leader, Outpatient Services	New Port Centre
Faith Boulton	Home Support Worker	AIDS Niagara
Albert Calaguiro	Executive Director	Wayside House
Rick Crysler		Regional Niagara Public Health
Carole Cullum	Program Secretary	Alcohol & Drug Treatment Centre (Niagara)
Diane Doneff	Executive Director	Women's Addiction Recovery Mediation
Glenda Edgar	Program Worker	Hotel Dieu Hospital - Addiction Services
Kent Gabel	Addiction Counsellor	New Port Centre
Marina Gauvreau	Housing Coordinator	AIDS Niagara
Dr. Peter Grant	Board Member	Alcohol & Drug Treatment Centre (Niagara)
Iona Hunter	Counsellor	Alcohol & Drug Treatment Centre (Niagara)
Linda Jolly		New Port Centre
Adrienne Jugley	Program Manager	Alcohol & Drug Treatment Centre (Niagara)
Kathy Katch	Home Support Worker	AIDS Niagara
Dave Kendall	Counsellor	Alcohol & Drug Treatment Centre (Niagara)
Sue Lewis	Counsellor	Alcohol & Drug Treatment Centre (Niagara)
Michelle Lyddiatt	Home Support Worker	AIDS Niagara
Norma Medulun	Manager	Hotel Dieu Hospital - Addiction Services
Paul Niesink	Clinical Supervisor	NADAS
Linda Palanek	Executive Director	NADAS

Name	Position	Organization
Natalie Phelan	Student - Occupational Therapist	Hotel Dieu Hospital - Addiction Services
Ian Robertson	Addiction Counsellor	New Port Centre
Lisa Root	Gambling Team Leader	NADAS
Heather Scott	Director	New Port Centre
Leonard Trebley	Support Worker	AIDS Niagara
Maria Vanvelzen	Counsellor	Alcohol & Drug Treatment Centre (Niagara)
Jim Wells		
Bob Wood	Program Worker	Hotel Dieu Hospital - Addiction Services

APPENDIX G

CONSULTATION - SERVICE PROVIDERS
SUMMARY REPORT

RESULTS FROM SMALL GROUP QUESTIONS

1. What are the strengths of the existing Niagara addiction service system?

GROUP 1

- accessibility
- cooperation with agencies (i.e., universal consent form; A.S.M.C
- Good clinical programming
- Almost full continuum of care
- Specialized services
- Research based programming
- Part of pilot projects/provincial outcomes
- huge progress made in our system
- Being duplicated by other sectors and geographical areas
- No waiting period for service
- Methadone services in Niagara

GROUP 2

- Key players in the system are well networked
- Different service philosophies give consumers more choice
- Good range of services for persons in the action stage of treatment
- Some connection with non-addiction specific services

GROUP 3

- Definite flow
- Fairly good working relationship with service providers
- Stable services (been around awhile)
- Service expansion (ie. Methadone)
- Service efficient increase accessibility
- Service Flexibility - Lots with little - gambling; women/child care; choices/mandate
- Diversity of agencies with services for broader need clients
- More pre-treatment outpatient
- More post treatment arrangements

GROUP 4

- Immediate access to care
- Variety of treatment options for different populations

- Diversity - approaches and philosophies
- Improved of services outside of the addiction services
- Adequate recovery housing for males
- Gender-specific services

2. What are the gaps and challenges in the current addiction service system?

GROUP 1

- Lack of women's residential recovery home
- Do more with less
- Complexities of clients
- Continuum of care for youth is lacking
- Improve case management
- Not multi-disciplinary in nature (enough)
- Shitty salaries (train and retain staff)
- Maintain learning environment
- Benchmark to compare "new" system with after reintegration (evidence based)
- Should we be integrating with other systems? (i.e., mental health)
- Client transportation budget = $0
- Lack of alternative housing options (i.e., women and youth)
- School-based counselling not able to staff undercurrent level
- Psychiatrists, specialists in addictions needed
- Funding and mandate needed to do prevention effectively

GROUP 2

- Low salaries for workers in system causes loss of experienced workers
- Women's halfway house is needed
- Creation of outreach services
- Increase methadone accessibility
- Access to programs limited due to lack of psychiatric; physicians
- Concurrent treatment of MH and addictions
- Drop-in Centre specific to Women
- Aftercare needs to be more integrated
- More beds for men awaiting treatment
- Special populations ABI; disabled

GROUP 3

- Women's services - recovery home; physicians not enough; eating disorders; treatment; child care
- Accessibility to Physicians and publicly funded programs (anger; psychological, etc.)
- Mandated clients
- Seniors
- Education (i.e., with medical com; treatment providers

- Communication early identification
- Standard Assessments
- Liaison, linkage with services
- New tech. Addictions youth/games, internet
- Mental health is getting better but still there is need for improvement, i.e., training; consultation (doc/nurse/psych); lack of resource "safe bed".
- More networking - brown bag luncheons

GROUP 4

- Inadequate recovery housing for females (day care; transition facility; transportation)
- Inadequate family services across agencies
- Inadequate funding for family services
- Need for increased family awareness/recovery across agencies
- Inadequate mental health supports (psychiatric assessments; not enough psychiatrist resources for clients; general lack of knowledge and training in psychiatry and general) -- we are having to become all things to all people.
- No direct service providers or consumers on task force
- Sexual abuse counselling for males and females and training for front-line staff
- Correctional clients are being abandoned by the system
- Having to work with child and family organizations which are chaotic
- Failure of policing to reduce crack houses
- Programming for youth - under 18
- Lack of understanding of harm reduction
- Pay inequity
- lack of training
- Lack of government commitment (outcome measuring; standardization; moving the field ahead)
- Lack of services for seniors

3. What makes it difficult for clients to access addiction services in our community?

GROUP 1

- Transportation
- Child Care
- Location of agencies - awareness
- Lack of family docs and psychiatrists
- Financial difficulties
- Up-to-date communication between social service network
- Educating public
- Waiting periods or perception of.

GROUP 2

- Waiting lists

- Restrictive policies and procedures
- Transportation
- Lack of physician and psychiatrists
- Child-care services
- Services being full require out of region referrals
- Number of treatment spaces available

GROUP 3

- Fear (i.e., employer knows, I'm fired)
- Transportation
- Child care
- Housing
- Money
- Wait lists - improved now but could improve (different for connection)
- Mental health and special needs - length of time to wait

GROUP 4

- Lack of understanding of client information and resources
- Cultural and language issues
- Lack of marketing plan by agencies for the system.

4. What can be done to increase the capacity of our addiction treatment service to meet more complex needs and increased client volume?

GROUP 1

- More staff, money, training, facilities
- Less rationalization meetings
- Seek further understanding/flexibility and cooperation from the government with regards to our needs
- Government needs to be more contemporaneous

GROUP 2

- Social service need to be aware addictions services "best practice"
- More cost effective decision making
- Increase formal collaboration between addiction and mental health (i.e., formal service delivery contracts)
- Increase collaboration between addictions, gas, social servies, legal, etc.

GROUP 3

- Complex needs - awareness, how to access other services needed; increase professional development; $; evening services increase - flexibility dep. On population to be served
- Walk -in concept
- Continuous intake

GROUP 4

- Funding for additional staffing
- Evening programs in Welland, Niagara Falls, Fort Erie, Port Colborne
- Satellite family program to outside agencies, e.g., FACS.
- Are we really meeting client needs?
- Constructing focus groups
- Follow-up surveys
- Longitudinal studies to see how effective programs are.
- Educating the referral sources

5. What are the pros and cons of integrating client treatment services in Niagara?

GROUP 1

Strengths

- Evidence based partnerships, group work, education sessions, harm reduction strategies
- Provincial profile is high

Pros

- Take this question to ASMC will it save $$??
- Less paperwork with integrated info system
- Improve client service
- Client friendly
- Cost efficient

GROUP 2

Pros

- Information flow
- Networking
- Easier to identify and address gaps
- Easier to case manage
- Fiscal Responsibility through reduced management
- Reduce duplication of service
- Increase front-line staff
- Equalisation of staff salaries
- Increase effectiveness of case management

Cons

- Reduce possibility of diverse philosophies; decrease client choice
- Large organization are slower to
- Job loss
- Potential loss of confidentiality
- Geographic/transportation problems.

GROUP 3

Pros

- need for more integration (i.e., mental health within and outside of addictions network
- Special needs more networking with existing committees (i.e., NASS
- Consultation/coordination

GROUP 4

- Any duplication of outpatient services - what are the differences?

Pros

- save program duplication
- better understanding, reduces confusion
- Less administrative duplication

Cons

- What happens to programs for community - loss?
- Loss of diversity
- One administration tunnel vision - choice of programs might be reduced.

6. ***Do you think the Niagara addiction system has the required range of services? Please comment.***

GROUP 1

- No answer.

GROUP 2

- Transition house
- Concurrent MH and Addictions
- Pre-treatment beds
- Drop-in Centres
- Satellite services
- Seniors specific services
- Maintenance phase treatment service
- Increase prevention services
- Specialized populations

GROUP 3

- Yes except for areas identified in Gaps question 2.

GROUP 4

- Recovery home for women
- Different treatment approaches for youth - age appropriate - under 18
- Senior Services (transportation; programming)
- Increased family services
- Correction clients

7. ***Does the Niagara addiction system meet the needs of the following clients? In what ways can these services be improved?***

Target Group	Meet Need (yes/no) and Recommendations for Improvement			
	Group 1	Group 2	Group 3	Group 4
Youth	Partial --Need residential treatment, day treatment, more staff to service schools, more detox services, staff for more family services. Research evidence based outcomes. Under 16 age group? Public health - cooperative effort. Housing (safe). Better ties to other youth services	No -- School outreach; under 16 not served; not enough residential beds; CDC; NCYC	No -- A whole range of treatment specific for youth (residential; housing; detox; aftercare)	No
Women	Partial -- recovery home for women; staff for Branscombe House	No -- Housing; post-treatment; pre-treatment	No -- Recovery home, child care	No
People with HIV/AIDS	Yes	No -- Harm reduction options need to be available	No -- More methadone treatment; more knowledge	No -- Harm reduction misunderstand
Francophones	Yes -- More formal link to Centre for Health Services in Welland	No need, minimal request for services	Yes -- No identified need; other language no	Yes -- But, no for other language
Homeless individuals	Connect with DHC committee on this issus	No -- Housing (supportive); harm reduction	No	No
People with disabilities	Partial -- not all wheelchair accessible; money for retrofitting.	No -- Accessibility; outreach services; CCAC with addiction	No	No -- Programming for agencies
Families	Yes. Family system approach is growing	No -- Child care	Yes -- Have walk in clinic; need some for residential treatment	No
Older adults	NASS is in place - growing and needs resources	No -- Specific services; increase awareness to identify seniors	No -- NASS	No
Individuals with concurrent disorders	Partial -- Better coordination of services; clarification of services; proper assessment.	No -- Concurrent treatment programs	No -- Need improvement	No

Target Group	Meet Need (yes/no) and Recommendations for Improvement			
	Group 1	Group 2	Group 3	Group 4
Aboriginal people	Partial -- Needs enrichment; public relations needed; region wide; cultural sensitive training; range of services for this group	No -- Culturally appropriate treatment	No -- Great need for networking; not addiction specific	No -- Female high rate of drop out
Ethnocultural communities	Partial -- Needs enrichment; public relations needed; region wide; cultural sensitive training; range of services for this group	Not request often, address when arises	No -- Not sure	No
Gays, lesbians, bisexuals	Outpatient - yes; Residential ?? Relationship counselling for families of.	No -- Specific services; education and issues to staff	No -- Special needs group; education	No - ? explore programming for
Problem gamblers		Yes	Yes	Just getting a handle
Individuals in the corrections system		No -- Integration back to community; diversion programs	Yes -- Integration back issues	No
Comments		Stigma on issue when working with other agencies		

8. ***How would you suggest that the addiction system ensure that quality care is being provided in each service?***

GROUP 1

- No answer.

GROUP 2

- Formal links with exchange of service between mental health and addiction
- Triage system - case management
- Common database
- Ongoing staff development
- Increase awareness of referral agents to identify and refer appropriately
- Evaluation of services
- Human resources (#s of staff; keeping skilled workers)
- Use of technology
- Keeping choice in system

GROUP 3

- No answer

GROUP 4

- Outcome studies (3 months; 6 months; one year)
- Increased funding
- Personal staff evaluations by management and client feedback
- Do we measure our programs by our mission statement?
- Focus/discussion group between front-line staff
- Network building - relationship between staffs (training of staff; problem solving, professional advisory groups)

APPENDIX G

CONSULTATION - COMMUNITY STAKEHOLDERS EVALUATION RESULTS

Total participants = 29 Total evaluations completed = 19

1. ***Overall how would you rate this consultation?***

   A winner = 1 Met it's objectives = 11 Not sure = 7

2. ***What I found helpful was:***

- Group discussions.
- Cooperative effort.
- Liaison with other agencies.
- Hearing the same needs identified from a variety of services.
- Connecting with others.
- We need to educate our own system better.
- Discovery that there is diverse opinion, understanding within the system.
- Meeting other players from different agencies.
- Intro that briefed on goals of Substance Abuse Bureau. Discussion with colleagues. Seeing how everyone has similar ideas for improvements.
- Networking, sharing thoughts and what other services are doing.
- Networking.
- I found all the information to be informative and interesting.
- Discussion with colleagues.
- Share different perspectives with other addiction workers.
- Discussions with a group of varied service providers and able to see similar concerns and beliefs.
- This was great to collaborate the needs in the system with other agency providers.
- The views of each person.
- Awareness of the range of services available.

3. ***What I found less helpful was:***

- Contradictory perceptions of what services were available and gaps that existed.
- Questions on integration.
- More time to understand the system.
- Things we have already done over and over again.
- Regeneration of same old.

- How the review of small groups was done - repetitive.
- How will this info be used? Did all ideas get fully represented?
- Answering some questions yet again.
- Lack of time to think.
- Going over each chart at end of afternoon.
- Budget restrictions - the principal of scarcity.

4. Other comments/suggestions:

- Good job.
- Are you getting feedback from consumers.
- Please this is getting repetitive.
- Wonderful cookies
- A little more time and a more formal wrap up would be helpful. Very good facilitation by Heather Chalmers.
- I hope we come together to brainstorm again.
- Wait and see if we use heard, or whether this is just an exercise in group therapy.

APPENDIX H

Consultation – Focus Group
For French Speaking Individuals

- ***List of Participants***
- ***Summary Report***

APPENDIX H

CONSULTATION - FOCUS GROUP
FOR FRENCH SPEAKING INDIVIDUALS
LIST OF PARTICIPANTS / SUMMARY REPORT

November 30, 1999

LIST OF PARTICIPANTS:

Jocelyn Blais-Breton
Gerard Holmes
Louise Mercier
Linda Palanek
Penny Pomeroy
Norma Ritz
Heather Scott
Adèle Tanguay

SUMMARY REPORT:

Heather presented an overview of addictions services in Niagara. She covered the areas of Detox, community treatment, day treatment, New Port Centre, recovery home, and addiction medicine/harm reduction. She reported that most promotion/prevention and outreach activities are carried out by NADAS and New Port. These two agencies also cover the three schedule 1 hospitals (re: concurrent disorders).

Penny provided background to the DHC addiction services review.

Gerard reviewed recommendations concerning francophones from the 1997 addiction services review.

Discussion areas included prevalence of addictions problems among francophones, need for outreach services to reach francophones, factors affecting demand for francophone services, potential partnerships with francophone service providers, role of Centre de Sante Communautaire, residential service needs, detox service needs, changes to Ontario Works, and newcomers requiring french language services.

On the basis of the focus group, Question 12 of the Substance Abuse Task Force Report was answered as follows:

SATF Report: Question #12:

Describe a strategy and plan for implementing French language services.

A Francophone focus group was held on November 30, 1999 at the Centre de Sante Communautaire in Welland. The following strategy for implementing French language services was agreed upon by those in attendance.

At the present time, there is only one francophone addictions worker in Niagara (located at the New Port Centre). Addiction service providers (including New Port) report that they experience little demand for services in French.

The focus group agreed that one of the reasons for this lack of demand may well be that people don't tend to ask for services that they don't perceive to exist. So francophones comfortable with english utilize generic addictions services and those uncomfortable with english do not utilize any addictions services. Also, in a broader cultural context, addiction service agencies in Niagara are seen as "anglophone agencies" and some francophones, regardless of comfort level in english, prefer to deal with "francophone agencies" rather than use generic services.

(In addition, it was pointed out that some refugees and immigrants speak neither english or french as a first language but in fact speak french as a second language and should therefore also be offered services in french.)

The Centre de Sante Communautaire is clearly perceived as a "francophone agency" and is thought of as a hub of francophone services in Niagara. At the present time, the Centre is working with about six clients with addictions problems, two of whom speak little english. In terms of outpatient treatment, it would seem most effective for Niagara community treatment services to place a francophone worker at the Centre in Welland. This worker could see clients at the Centre and also provide outreach services from this location. In addition, some in-service training could be provided for other staff at the Centre.

Detox services were seen as posing more challenge and it was suggested that supported community withdrawal or medical withdrawal at Welland County General Hospital be explored as options for francophone detox clients.

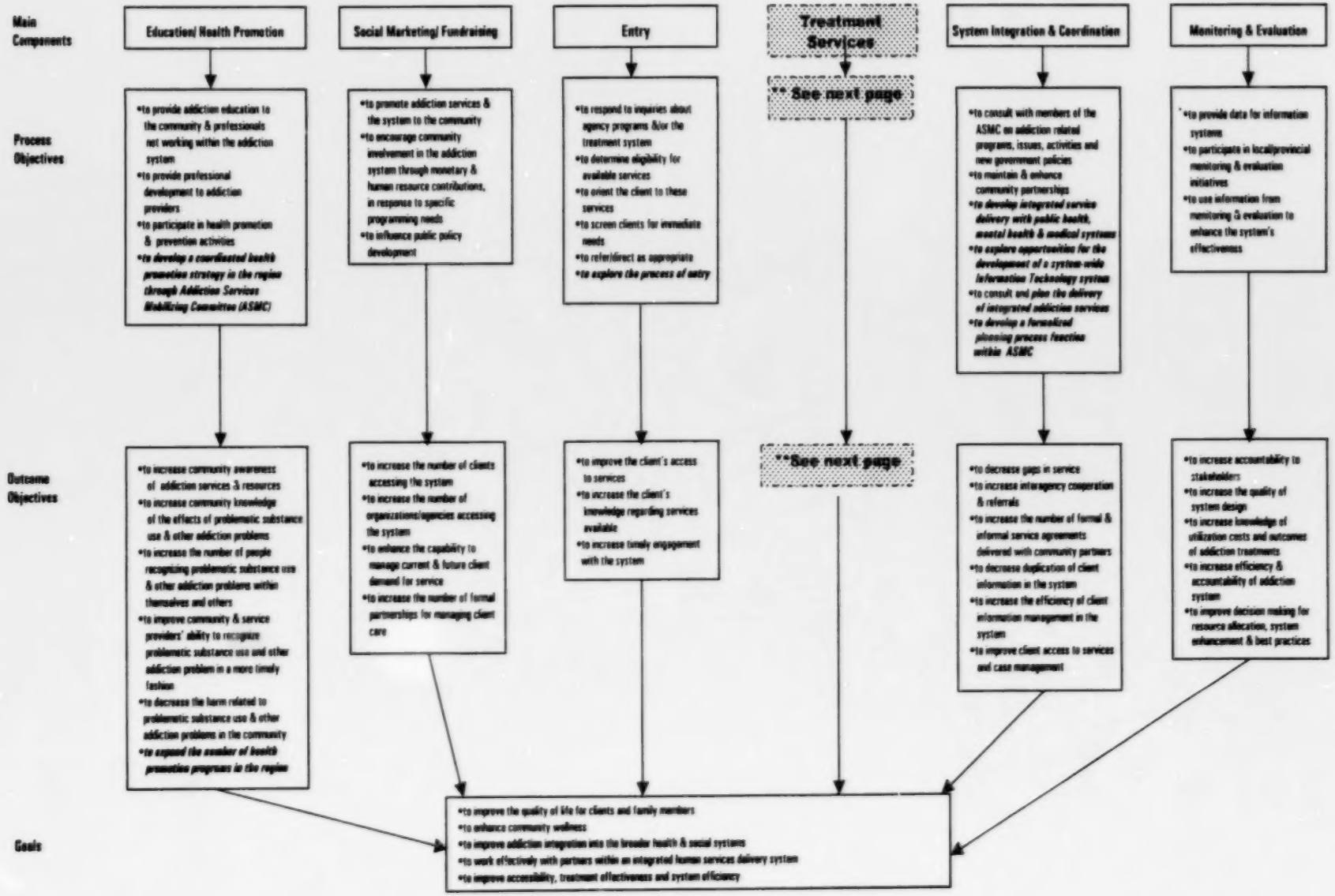
In terms of residential treatment, it was felt that a francophone centre was needed to serve the southern part of the province (central east, central west, central south and southwest) but that this centre did not necessarily have to be located in Niagara.

APPENDIX I

Niagara Addiction Treatment System Logic Model

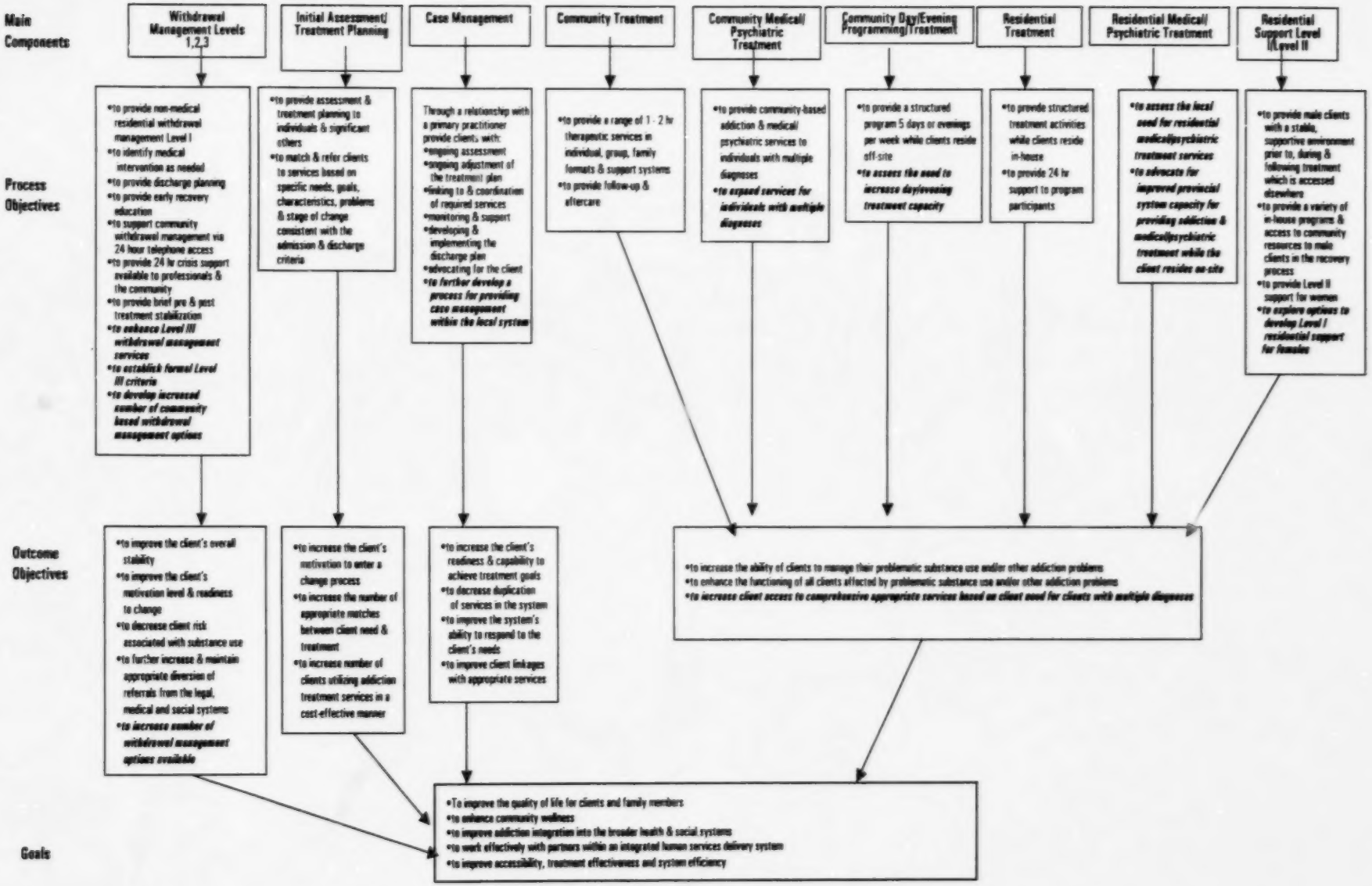
Niagara Addiction System Logic Model

Mission Statement: To maximize the capability & capacity of the local treatment system to treat and support individuals and families with addiction issues by providing, in partnership, the following functions at a system level


Main Components
Process Objectives
Outcome Objectives
Goals
Education/ Health Promotion
Social Marketing/ Fundraising
Entry
Treatment Services
System Integration & Coordination
Monitoring & Evaluation
•to provide addiction education to the community & professionals not working within the addiction system
•to provide professional development to addiction providers
•to participate in health promotion & prevention activities
•to develop a coordinated health promotion strategy in the region through Addiction Services MobilIzing Committee (ASMC)
•to promote addiction services & the system to the community
•to encourage community involvement in the addiction system through monetary & human resource contributions, in response to specific programming needs
•to influence public policy development
•to respond to inquiries about agency programs &/or the treatment system
•to determine eligibility for available services
•to orient the client to these services
•to screen clients for immediate needs
•to refer/direct as appropriate
•to explore the process of entry
** See next page
•to consult with members of the ASMC on addiction related programs, issues, activities and new government policies
•to maintain & enhance community partnerships
•to develop integrated service delivery with public health, mental health & medical systems
•to explore opportunities for the development of a system-wide Information Technology system
•to consult and plan the delivery of integrated addiction services
•to develop a formalized planning process function within ASMC
•to provide data for information systems
•to participate in local/provincial monitoring & evaluation initiatives
•to use information from monitoring & evaluation to enhance the system's effectiveness
•to increase community awareness of addiction services & resources
•to increase community knowledge of the effects of problematic substance use & other addiction problems
•to increase the number of people recognizing problematic substance use & other addiction problems within themselves and others
•to improve community & service providers' ability to recognize problematic substance use and other addiction problem in a more timely fashion
•to decrease the harm related to problematic substance use & other addiction problems in the community
•to expand the number of health promotion programs in the region
•to increase the number of clients accessing the system
•to increase the number of organizations/agencies accessing the system
•to enhance the capability to manage current & future client demand for service
•to increase the number of formal partnerships for managing client care
•to improve the client's access to services
•to increase the client's knowledge regarding services available
•to increase timely engagement with the system
**See next page
•to decrease gaps in service
•to increase interagency cooperation & referrals
•to increase the number of formal & informal service agreements delivered with community partners
•to decrease duplication of client information in the system
•to increase the efficiency of client information management in the system
•to improve client access to services and case management
•to increase accountability to stakeholders
•to increase the quality of system design
•to increase knowledge of utilization costs and outcomes of addiction treatments
•to increase efficiency & accountability of addiction system
•to improve decision making for resource allocation, system enhancement & best practices
•to improve the quality of life for clients and family members
•to enhance community wellness
•to improve addiction integration into the broader health & social systems
•to work effectively with partners within an integrated human services delivery system
•to improve accessibility, treatment effectiveness and system efficiency

Niagara Addiction System Logic Model

Treatment Services


Main Components
Process Objectives
Outcome Objectives
Goals
Withdrawal Management Levels 1,2,3
Initial Assessment/ Treatment Planning
Case Management
Community Treatment
Community Medical/ Psychiatric Treatment
Community Day/Evening Programming/Treatment
Residential Treatment
Residential Medical/ Psychiatric Treatment
Residential Support Level I/Level II
•to provide non-medical residential withdrawal management Level I
•to identify medical intervention as needed
•to provide discharge planning
•to provide early recovery education
•to support community withdrawal management via 24 hour telephone access
•to provide 24 hr crisis support available to professionals & the community
•to provide brief pre & post treatment stabilization
•to enhance Level III withdrawal management services
•to establish formal Level III criteria
•to develop increased number of community based withdrawal management options
•to provide assessment & treatment planning to individuals & significant others
•to match & refer clients to services based on specific needs, goals, characteristics, problems & stage of change consistent with the admission & discharge criteria
Through a relationship with a primary practitioner provide clients with:
•ongoing assessment
•ongoing adjustment of the treatment plan
•linking to & coordination of required services
•monitoring & support
•developing & implementing the discharge plan
•advocating for the client
•to further develop a process for providing case management within the local system
•to provide a range of 1 - 2 hr therapeutic services in individual, group, family formats & support systems
•to provide follow-up & aftercare
•to provide community-based addiction & medical/ psychiatric services to individuals with multiple diagnoses
•to expand services for individuals with multiple diagnoses
•to provide a structured program 5 days or evenings per week while clients reside off-site
•to assess the need to increase day/evening treatment capacity
•to provide structured treatment activities while clients reside in-house
•to provide 24 hr support to program participants
•to assess the local need for residential medical/psychiatric treatment services
•to advocate for improved provincial system capacity for providing addiction & medical/psychiatric treatment while the client resides on-site
•to provide male clients with a stable, supportive environment prior to, during & following treatment which is accessed elsewhere
•to provide a variety of in-house programs & access to community resources to male clients in the recovery process
•to provide Level II support for women
•to explore options to develop Level I residential support for females
•to improve the client's overall stability
•to improve the client's motivation level & readiness to change
•to decrease client risk associated with substance use
•to further increase & maintain appropriate diversion of referrals from the legal, medical and social systems
•to increase number of withdrawal management options available
•to increase the client's motivation to enter a change process
•to increase the number of appropriate matches between client need & treatment
•to increase number of clients utilizing addiction treatment services in a cost-effective manner
•to increase the client's readiness & capability to achieve treatment goals
•to decrease duplication of services in the system
•to improve the system's ability to respond to the client's needs
•to improve client linkages with appropriate services
•to increase the ability of clients to manage their problematic substance use and/or other addiction problems
•to enhance the functioning of all clients affected by problematic substance use and/or other addiction problems
•to increase client access to comprehensive appropriate services based on client need for clients with multiple diagnoses
•To improve the quality of life for clients and family members
•to enhance community wellness
•to improve addiction integration into the broader health & social systems
•to work effectively with partners within an integrated human services delivery system
•to improve accessibility, treatment effectiveness and system efficiency

APPENDIX J

Niagara Addiction Treatment System: Current Partnerships

APPENDIX J

NIAGARA ADDICTION TREATMENT SYSTEM: CURRENT PARTNERSHIPS

SERVICE AGREEMENTS

- Niagara Alcohol and Drug Assessment Service (NADAS) and AIDS Niagara
  - Formal service agreement
- NADAS and Community Mental Health Program, Regional Niagara Public Health Department
  - Formal service agreement, St. Catharines only
- Alcohol & Drug Treatment Centre (ADTC) and Hotel Dieu
  - Management service agreement- consultation and purchasing.
- Healthy Lifestyles Coalition and New Port Centre
  - Formal service agreement – management
- ADTC and Drug Awareness Week Committee
  - Formal service agreement - management

PARTNERSHIPS

- NADAS – Outpatient, Treatment, Education & Counselling Program (NADAS – OTEC) and Niagara Centre for Youth Care (NCYC): Family walk-in clinic, St. Catharines
- NADAS – OTEC with Centre for Addiction and Mental Health, Public Health Department, Region of Niagara and local high schools
- NADAS and Niagara Detention Centre: assessment services, contemplation group
- NADAS and St. Catharines General Hospital: in-hospital services for individuals with concurrent disorders
- NADAS-OTEC: School-based programs across the region
- WARM and NADAS: informal agreement to complete assessments
- Women's Addiction Recovery Mediation (WARM) and ARID Group Homes: resource sharing
- Detox hosts AA and ALNON
- Wayside House and ADTC: informal arrangement for day treatment intake one morning per week
- Fort Erie Native Centre and Detention Centre: provide education program for aboriginal peoples
- New Port Centre: provide off-site community treatment at WCGH, GNGH and CARSA
- New Port Centre and Port Colborne General Hospital, Dr. Wilkes: eating disorder program
- New Port Centre and Port Colborne General Hospital methadone clinic: New Port Centre staff provide 15 hours per week
- New Port Centre and Niagara Detention Centre: Choices program, as needed
- New Port Centre and NCYC: community walk in clinic in Port Colborne

- New Port Centre and Welland County General Hospital and Greater Niagara General Hospital: services for individuals with concurrent disorders
- Addictions Services Mobilizing Committee

COMMUNITY NETWORKS/ASSOCIATIONS

- Methadone committee
- OTEC and Brock University: youth research
- Detox and Hard to Serve Committee (community crisis mental health services)
- Employee Assistance Programs (EAP) Council and addiction treatment service agencies
- Housing options task force and addictions
- Addiction Services for Seniors (Niagara)

APPENDIX K

Consultation – Community Stakeholders - "Draft" report

- *Summary of Written Comments/Feedback*
- *List of Participants*
- *Summary of Comments From Community Consultation - January 7, 2000*

APPENDIX K
SUMMARY OF WRITTEN COMMENTS/FEEDBACK

ORGANIZATION/CONTACT	COMMENTS
Alcohol Drug Treatment Centre Niagara: D. Higgins, Chair, Board of Directors	Insufficient time for the board to provide a response by requested date. Will provide comments to SATF and OSAB after January 20th board meeting.
WARM: Diane Doneff, Executive Director	Board of Directors does not meet until January 20th. Request an extension.
Individual; name not provided.	1) Partially support recommendations. I feel the committee is doing the right thing. The recommendations are good only if they can be implemented. I think the government will not accept these recommendations and will strip even more of our services away. The agencies have to learn to work together a little better. They cannot get along now. There are some good recommendations and some bad ones. 2) (The recommendations) are meant to enhance the quality of service, but I don't think they will. As I stated above, "Things are now good. They just need a little fine tuning and cooperation". Cooperation is the key here. These ideas can be accomplished without integration and cooperation. 3) Changes to recommendations: #1. No need to change name of ASMC. #4. There is no need to merge these agencies into a new organisation. Services can be improved if each one gets funding that it needs. #12. Watch what type of doctors you are dealing with. Make sure the proper personnel are used. #13. Again watch who you deal with. #16. I strongly disagree with methadone. It should not be used. The client is just substituting. 4) If there is to be any integration, the main office should be in St. Catharines with satellite offices throughout the region. 5) I feel the committee did an excellent job on this. My biggest fear is that the government will not live up to their work, and will cut even more funding.
NCYC	1) Support the committee structure of the new network. 2) In the long run. 3) Time lines for studies and implementation #7.

ORGANIZATION/CONTACT	COMMENTS
AIDS Niagara: Steve Byers, Executive Director	1) Supported in principle. Read summary. 2) Yes, not able to fully review or to meet with other agency staff. 3) Be sure to maintain several types of services, e.g., high and low threshold, not purely abstinence-based. Should not loose "identity" during transition period. Continued communication as to on-going development with partners.
AIDS Niagara: Jim McKinnon, Streetworks Coordinator	Staff did not have sufficient time to respond. Request an extension.
Wayside House: A. Calaguiro, Executive Director	Board of Directors requested an extension.
Individual; RN, BSN	1. Vision statement appears good on paper. I have concerns about bringing together various organisations. They will be bringing their old baggage with them and may be resistant to evidence-based approach. Mutual respect for varying philosophies of addiction treatment is well intended; however, treatment That is evidence-based and reinforces by multiple studies should be made available as a treatment choice for all individuals. The clients need to be completely aware of options that are available, and the success of those treatments. Informed consent is essential. 2. The recommendations contained in the draft report will enhance quality of service. Without a doubt, addiction treatment is a 24-hour, 7 days a week service. Addiction services can no longer expect to provide adequate care 9-5 M-F. I firmly support education. I am astonished at the lack of knowledge of addiction programs. The report speaks to community training and I firmly believe this comity includes hospital staff and physicians. I would recommend women-centred treatment. In this environment, women rediscover how they make choices, independent decisions, and self-value. Substance abuse affects the whole family and so increased funding is always needed to provide childcare for mothers undergoing treatment. The adolescent cannot be forgotten, and when we have an adolescent pregnancy combined with drug use the adolescent may not seek prenatal care early because the addiction problem may be discovered. Perinatal nurses are an important part of the addiction team. I find difficulty calling the system "integrated" if French-only is used for areas designated "French". Are duplicate files going to be available to case managers if client seeks other services?

ORGANIZATION/CONTACT	COMMENTS
Individual; RN, BSN (continued)	3. Recommendations for methadone treatment were not satisfactory. Methadone is usually most effective in a comprehensive service centre where group, family counselling, women's' obstetric health and psychiatric care is available (Jarvis and Schnoll, 1994). Methadone reduces drug-seeking behaviours that can include prostitution, dirty needles, and risk for hepatitis BC and HIV. Methadone maintained women might experience withdrawal as pregnancy progresses, needing an increase of oral dosage (Kaltenback et al, 1998). Patients need constant care. I experienced frustration calling around the region for help for a pregnant client on methadone. I did not find a human voice to talk to, just voice mail machines. Nurses caring for adolescents need to be able to assess for signs and symptoms of substance abuse. In reading through the Treatment Service Plan, I support the recommendations with an added emphasis on substance abuse education for the region.
Addiction Services Mobilizing Committee: Adrienne Jugley, Chair	Due to time constraints only half of committee members were able to provide their comments. Committee supports in principle recommendations #1, 2, 3, 21 and 22. Believe it is absolutely critical that a coordinator is hired; concerned that two years of funding may not be sufficient. Suggest that once the Addiction Treatment Network of Niagara (ATNN) is established, the other recommendations be then considered pending the completion of a more comprehensive needs analysis. It would also be necessary to prioritise projects and complete qualitative and economic evaluations of treatment services in Niagara. **Comments on other recommendations:** #4. Suggest that ATNN undertake a full review of the clinical, programmatic and economic implementations of the community treatment merger. It is unlikely that this merger can occur without significant loss of service. Other recommendations related to central access, case management and client information systems may address service needs. With shift from residential to community-based services, there will be an increased demand for community treatment services. #5. Supportive. #6. Supportive. Not clear on Niagara Partners in Service project regarding centralised data collection and electronic client file. #7 and 15. Supportive. #8. Supportive. Further evaluation of need be undertaken by ATNN. #9. OSAB is providing training. Would suggest that training be provided to the larger health and social service systems in Niagara. #10. Supportive. As this would require additional resources, suggest ATNN consider this further. #11. ATNN review further. Support meeting with the new Niagara Health System.

ORGANIZATION/CONTACT	COMMENTS
Addiction Services Mobilizing Committee: Adrienne Jugley, Chair (continued)	#12 and 13. Supportive. Recommend that the ATNN consider the use of sessional fees to negotiate access to specialised services. #14. Suggest ATNN study the need further. #16. Supportive. #17 and 18. Support a collaborative effort in the provision of French language services. ATNN determine if this can be accomplished through seconded staff or if additional funds are needed. #19. Recommend the provincial residential group consult with ATNN regarding any recommendations for French speaking clients. Support feasibility study for French language services in southern part of Ontario. #20. Recommend a comprehensive budgetary review be conducted immediately. In summary, a number of recommendations will require clinical, programmatic and economic analysis and also require addition funding. Given the latter, ASMC is concerned about any immediate implementation without such an analysis, particularly given the OSAB position of "no new money". Would have a preferred an open, consultative and invested process that would have involved all of the stakeholders responsible for, and interested in the provision of services. It is hope that such a process can occur under the leadership of ATNN.

APPENDIX K

LIST OF PARTICIPANTS
STAKEHOLDERS - COMMUNITY CONSULTATION
January 7, 2000

AGENCY	NAME
Alcohol & Drug Treatment Centre (Niagara)	Carole Cullum
	David Higgins
	Iona Hunter
	Adrienne Jugley
	Dave Kendall
	Shirley Ann Ogilvie
	Maria Vanvelzen
ARID	Ken McKenzie
Canal View Homes	Willy Mason
City of St. Catharines	Joe Smith
Dana Corporation	Bob Campbell
	Hugh McDonald
Hotel Dieu Hospital	Barb Chrysler
Job Creation Partnership Project	Jean Irish
Labyrinth	Sherri Boyer
New Port Centre	Chris Baldissera
	Larry Dahmer
	Kenton Gabel
	Jim Hanna
	Jennifer Herman
(continued)	Heather Hogan

AGENCY	NAME
New Port Centre (continued)	Sue-Ellen Merritt
	Doreen Morey
	Ian Robertson
	Heather Scott
	Denis Wilson
Niagara Alcohol & Drug Assess. Service	Paul Niesink
	Linda Palanek
	Lisa Root
Project SHARE	Roxanne Felice
Regional Mental Health	Rick Crysler
Regional Municipality of Niagara, Ontario Works Div.	Jim Wilsher
	Cheryl Stock
USWA	Don Crocock
W.A.R.M.	Donna Booker
	Diane Doneff
	Mary Minor
Wayside House	Albert Calaguiro
	Jim Wells
Women's Detox Centre	Norma Medulun
	Joan Caira
SATF Members	Mary Dobson
	Phil Durrant
	Lisa Horvatek
	Sue Raymond
Ex-Officio/NDHC Staff	Vicky Guertin
	Penny Pomeroy
	Gary Zalot

APPENDIX K

SUMMARY OF COMMENTS FROM COMMUNITY CONSULTATION - JANUARY 7, 2000

Establish Addiction Treatment Network of Niagara (ATNN)

- System needs common vision to make ATNN work.
- ATNN is model of governance for the system.
- Makes sense to have a coordinated body to determine & prioritize needs in Niagara.
- Support idea of coordinating body – need more investigation, needs analysis. What is already working well?
- Do not need to create another site.
- Is it advisory/administration? Role unclear/lack of structure. What is authority?
- Unless there is authority, ATNN will not work
- Need more clarification on governance. What will be the relationship with OSAB, local agencies and DHC?
- Function of ATNN would be to provide bona fide needs assessment vs. the squeaky wheel.
- Objection to ATNN (volunteers) having authority re: operating plans.
- Bureaucratic layer or will it have discretionary power?
- Buy in from involved agencies – how to ensure?
- Ensure fair representation by all players. Who decides representation?
- Membership of board members questioned. Should consumers and family members be included? Have some difficulty with authority of the network.
- Is one paid position sufficient? What happens after two years? Is there an expectation for the position to continue?

ATNN and Community Education

- There are things that could be done centrally. It would help to develop common vision.
- Great idea, even if only communication system is set up.

Establish Central Access

- What is the role? Gate keeper role? Info providing?
- Is access a problem?
- What concern will a centralized # address?
- Is it affordable?
- There is support for centralised electronic data.
- Have some confidentiality concerns.
- Should be hooked into case management.

Program Merger and/or Centralization of Community-based Treatment Programs

- Base on no cost.
- Need to look at current linkages.
- This may not translate into better client service
- If multifunctional agencies are direction, is the merger the best direction? It puts like-minded workers together, but may go against policy of multifunctional.
- What is the benefit? Where is evidence? What is benefit to clients?
- What services would be lost?
- Presumes duplication of administration.
- Better coordination?
- Require needs analysis and cost/benefit analysis.
- Alternative could be to strengthen muliti-panetinal efforts to date, or enhance service agreement and management contracts. Hire multidisciplinary staff (e.g., OT Nurse Practitioner).

Case Management

- Need clear definition of case management.

Protocols of Service and/or Medical Psych Treatment

- Already trying this.
- Struggle with access to services.
- There is a lack of psychiatrists.

Services for Special Populations

<u>Women</u>
- Housing needs for women in general is a concern.
- Require a needs assessment to establish a residential recovery level 1 for women.

<u>Methadone Clients</u>
- Investigate other ways to support, i.e., drug companies?
- On-going funding is a challenge.
- How do we objectively evaluate programs
- What is accountability for this service?
- If it is physician-run, do we lose opportunity to influence?

<u>French Language Clients</u>
- Is there a need for funding language specific service – needs analysis.

<u>Youth</u>
- Need more staff.

- Do not need more "prevention". Public Health funding for this already more than sufficient.
- Need to explore previous model (circa '95) with NCYC.
- Support provincial recommendation for expansion of youth residential specific to Niagara youth. (Develop youth residential programs with New Port?)
- Develop youth day treatment programs with:
  - Youth mental health services in Niagara;
  - South Central Ontario linkages (i.e., Hamilton, Haldimand-Norfolk etc.).
- Do not lose youth focus and existing expertise (special population/special needs).
- Withdrawal management services for youth need to be enhanced.
- Need street outreach for youth (i.e., RAFT, Lighthouse, and Streetworks).

Seniors

- The expertise in these areas does not exist to a level needed to serve this rapidly growing population.
- Seniors needs are not like any other groups needs (substance metabolism, drug combinations, handicaps, access to service, mobility, supportive services, communication, etc.).

Expand Community Withdrawal Management Services

- Needs further discussion, as there is cost involvement.
- Loot at internal restructuring, i.e., is it a detox issue, community treatment?

Establish Beds for Level 3 Withdrawal Management

- Needs to be further defined to determine whose role it is.
- Protocols need to be developed before access.

Protocols of Services

- Anything we can do to see ourselves in contact with both mental health and public health is good.

Other Comments

- Any new service should be first assessed based on quantitative and qualitative and best practice analysis.
- Explore entrepreneurial opportunities.
- Non-abstinent services, of which methadone is part, needs a thorough needs analysis and best practice review before restructuring takes place.
- Accessibility in the Region is an issue.
- Chronic underfunding of the addiction system & specific services (e.g., women and WARM) is a problem.
- Needs of other language groups/cultural groups?